| | | | . For | icase i | State of | | | | | | | | | _ | ic. | |
|--------------------------------|---|-------------------------------|---|-------------------------------|---|------------------------|-----------------------|---|-----------------------------|-----------------------|------------------------------|----------------------------------|--------------------------|--------------|-------------|--|
| | | | 1 - State Registrar | | | | (| Certifica | te of | Deatl | ל | | Reg. No | 200 | 16 | 37501 |
| | Physici | an | 1. Decedent's Name (First, I | | _ | | | | | | | 2. Date of D Month | Da | ay, ' | Year | 3. Time of Death |
| 1 | /Medio | cal | Nellie Ruth 4a. Facility Name (If not inst. | | | er) | | 4b. City | , Town, o | r Location | of Death | 11 | 2 | County o | Death | 7 |
| | Examir | ier | FRANKlin | < | uaro | Hose | 1.40 | 1 | Bo |)5pg | 1 | 0 | 1 5 | Bal | | 1000 |
| | Funeral | | 5. Social Security Number | 6. Sex | 7. | Age (In yrs. | | Months | er 1 Year Days | | r 24 Hrs. | 8. Date of Bi (Month, D | irth | | 9. Birthp | lace (State or Foreign |
| | Director | | 220-20-7717 Usual Residence of Decede | | M 2∏F | 80 | - Yı | rs. | | | | July 2 | 25, | 1926 | Mar | ýland |
| | rland | | 10a. State 10b. Co | | | 10c. Ci | ty, Town | or Location | | | | | | | 1 | 0d. Inside City Limits |
| | a-fet | ctor | Md. B | altimo | re | | | Balti | more | | | | | | | 1 ☐ Yes 2 🖾 No |
| | with the Maryland is or 28s-1 ehow | Dire | 10e. Street and Number | | | | | 10f. Z | ip Code | | | | 10g. C | itizen of Wi | | ntry? |
| 11) | deeth w | eral | 207 Middlew | | | net Ever in 1 | 10 | 13 Was Door | | 21220 | | ofy Voc or N | | U.S. | | can Indian. |
| 7 0 | or Item | Fun | 11. Marital Status 1 □ Never Married 2□ | Marned | 2. Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give | s? ☑ No | ,.5. | 13. Was Dec | | | | Rican, etc.) | | Black | . White, | etc. |
| 3 | Phours a eturel, o | 1 by | 3 ☐ Widowed 4 ☐ Poivo | orced | If Yes, Give Year or Date | os: | | 1 🗆 Yes | 2 <u>اچا</u> No | Specif | y: | | | Specify: | wn | ite |
| MEUL 21215-0036 | 일 문제 | Completed by Funeral Director | 15. Dec (Specify only I | edent's Educ iighest grade | ation completed) | | 16a. [| Decedent's Us Give kind of w life. DO NOT | ual Occup | ation during mo | ost of workii | ng | 16b. l | Kind of Bus | iness/In | dustry |
| 7 | withir lene. then | dmo | Elementary/Secondary (0- | 12) | College (1-4 | or 5+) | c1e | | 030 10010 | <i>J</i>) | | | ho | spita | 1 | |
| | other vent, | BeC | 11 years 17. Father's Name (First, Mi | ddle, Last) | | | <u> </u> | | | 18. Mot | her's Name | (First, Middle | _ | | | |
| D in | Menta Menta arked | ToE | Stanley Le | | | | | | | My | yrt1e | Schu1 | ıder | berg | | |
| Mar | 12 sh h and 7 Is m Ireum | | James E. Jo | , , , , . | | | | Mailing Addres | | | | | | | | Code) |
| 元以及ice」 Baltimore, Maryland | permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importents if Item 27 is marked other then enty Injury or other treumatic event, the Mades. | | 20a. Method of Disposition | Jiles, | 31./5011 | | | Disposition (Na., crematory or | | | | ate | , | _ocation - C | | own, State |
| 7 8 | Pages ent of nt: If I | | 1 Burial 2 Crema 4 Donation 5 Oth | | emoval from Sta | ale | | crematory or w Crem | | l. | 11/28 | 3/06 | В | altim | ore. | Md. |
| LL 를 | Departm Departm Importe eny Inju | | 21. Signature of Fifteral Se | | 6 | | -, | | | | | Home of | | | | |
| _ | \$0 E \$ 9 | | 144 | lly | | | | 610 | W M | acPh: | ail Ro | ad Be | 1 A | | | 1014 |
| | | | 23a. Part1. Enter the disease shock, or heart failure. | e, or complic List only on | e cause on eac | sed the dea h line. | th. Do no | ot enter the mo | ode of dyin | ng, such a | is cardiac o | r respiratory | arrest, | | | Approximate Interval Between Onset and Death |
| O | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a. | | umor | | | | | | | | | | |
| | Examiner | | | | | as a consec | | Infe | 0400 | | | | | | | |
| | P == | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | J • | | as a consec | | | .Cero | 011 | | | | | | |
| 1/2. | be executed icien and burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | С. | Due to for | as a consec | | | | | | | | | | |
| ,760, | ite be executed sysicien and he burial-transit | calE | | ı, | 10) 01 9 00 | as a consec | desire of |). | | | | | | | | |
| 89 | 5 × 6 | | | d | | | | | | | | | | | | |
| Вох | eath certificat attending phy I for use as th | M/N | IF FEMALE: 23b. Was decedent pregnar | IL | c. If yes, outco | | | 3 □Ectopic | nreanancy | , | | | ŀ | 23d. Date | | |
| _ | e death | Physician/Med | in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | | 4□Pregnan 9□Unknow | t at time of o | | 5 ☐ Other (s | | | | | | Mon | th | Day Year |
| P.O. | that the | | Part II. Other significant co | nditions con | Inbuting to deat | h but not re: | sultina in 1 | the underlying | cause giv | en in Par | t I. | 23e. Did | tobacco | use contri | oute to the | he cause of death? |
| Division of Vital Records, | The law requires that the death certifica site has been signed by the attending ph page 2 should be detached for use as th | d by | | | | | | | | | | 1 | Yes : | 2.60 No : | 3 □ Prob | pably 4 Unknown |
| OS | aw rec is bee 2 shou | Completed | | | | | | | | | | 24a. Wa | | | | psy findings available |
| 8 | | Com | | | | | | | | | | per 1 Yes | opsy formed? 2 × N | de | eath? | mpletion of cause of 2 🗷 No |
| Vita | Physiclan: r this certifice ral director, p | Be | 25. Was case referred to me examiner? | | ospital: | | | | 0# | | ce of Death | (Check only | one) | | | |
| o | Phys r this ral dir | 2 | 1 Yes 2 No 27. Manner of Death | | 28a. Date of | | ER/Outp | | 28c. Injur | v at | | ne 5 Res 28d. Describe | | | _ | (v) |
| lon | nding ith. :: Afte e fune | atlon | 1 Natural 5 □ P | ending vestigation | (Month, | Day Year) | | ury M | Wor | rk? Yes 2[| | | | ., | | |
| ivis | r Atte | Certification: | | ould not be etermined | 28e. Ptace of | Injury - At h | nome, farr | n, street, facto | ory, office | | : | 28f. Location City or To | | | r or Rura | al Route Number, |
| Q | ors of | | | | | | | | | | | | | | | |
| | To the Hospitel or Attending Physician: within 24 hours elfer death. To the Funeral Director: Alter this certific completely filled in by the funeral director, | Medical | 29a. Certifier 1X Cer (Check only 2 Med | tifying Phys lical Examin | er: On the basi and manner | s of examina | owledge, ation and | death occurre for investigation | d at the tir on, in my o | me, date pinion, d | and place, a eath occurre | and due to the ed at the time | e cause(e, date a | s) and man | ner as s | stated. the cause(s) |
| | To the within To the | Me | 29b. Signature and title of ce | entitier / | , 11 | 7 | | 2 | 9c. Licens | e numbe | r | | 29d. D | ate signed | (Month. | Day, Year) |
| 1 | | | 1.6 | Via | UG | KI | 0 | WPH | R | 25 | 000 | 00 | İ | 1-21 | 4-0 | 06 |
| | 10 | | 30. Name and address of pe | rson who cor | mpleted cause | Our n | | | | | | | | | | |
| | Sta | to | DR. Carl M 31. Date filed (Month, Day, | iddle | 1324Ren | 900 istrar's Sign | ature | ROW KI | in a | Dq. | CR. I | Baltin | nure | MD | d | 1237 |
| | Registr | _ | NOV S | | 6 | Hilland at | J. A | docules | Þ | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene [] [] [37502 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 11 0340 2006 HAZIAH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center TOWSON
If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☐ M 2 🖾 F MD Director None Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 21 No Director MD Cockeysville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Itams 23a 21030 9 McCann Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No Il Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then College (1-4or 5+) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) Infant Infant 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ LaTova N. Edwards Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a 9 McCann Ave., Cockeysville, MD <u>LaTova N. Edwards (parent)</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) EN MOUNT CREMPON 22. Name and Address of Family 21. Signature of Funeral Service Licenses 150x560. 16924 XXX R. JOKTON ING. ZIIII. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Extreme Prematurity **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner use as the burial-transit Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No į 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown this certificate has been si al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 No 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manne of Death 1 Natural Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2006 November 23, D26112 1. 1 inner 30. Name and address of person who complete: cause of death (Item 23a) (Type, Print) 6701 N. Charles Street, Towson, MD, 21204 Norma V. Gungon Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 8 2006 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

21215-0036

Baltimore, Maryland

certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Hospital

| | | | For State Registrar | State of Mar | yland | | artment of rtificate of | | | ental Hy | /giene Reg. No | 200 | 6 | 37503 |
|------------|---|---------------------|--|---|---------------------|--|---|--------------------------------|-------------|------------------------------------|---------------------------------|--------------------------------------|--------------------------------|---|
| | Physicia /Medic | al | Decedent's Name (First, Middle, Last) Myrtle Ester Einh As. Facility Name (If not institution, give se | orn | | | 4b. City, Town, | or Location | of Death | 2. Date of D Month | Da 2 | | 06 | 3. Time of Death 2:31 Am |
| | Examin Funeral Director | | BELAIR He 5. Social Security Number 6. Sec | alth & | In yrs. I | hab, ast birthday) Yrs. | BEL If Under 1 Yea Months Day | A I | IR | 8. Date of Bi (Month, D | irth | 4AR | FO Birthpla Count | CD ace (State or Foreign y) Virginia |
| | 0 | or | Usual Residence of Decedent 10a. State 10b. County | | 0c. City | , Town or Lo | cation | | | Aug. | | 1922 1 | | d. Inside City Limits |
| | with the h | Direct | Maryland Harford 10e. Street and Number 543 Terrapin Terra | ace. | <u>U</u> | oppa | 10f. Zip Code | 085 | | | - | tizen of What | t Count | ry? |
| 36 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At them 27 is marked other then "neturel", or them 21s or 28s-f ahow or other traumatic event, the Medical Examinar maint be notified at | by Funeral Director | | 12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | er in U.S | | Was Decedent of f Yes, specify Cu | Hispanic Or ban, Mexica | | ecify Yes or N Rican, etc.) | | 14. Race - A Black, W Specify: | Vhite, e | |
| 21215-0036 | within 72 hou ene. then "neture he Medical E | Completed | 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) | cation e completed) College (1-4or 5+) | | (Give life. I | dent's Usual Occ kind of work don DO NOT use retii | upation e during mos ed) | st of worki | ng | | Gind of Busine | ess/Ind | ustry |
| Maryland 2 | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other then any injury or other traumatic event, the Moone. | To Be Co | 17. Father's Name (First, Middle, Last) Elmer Daniel Tusi | | | Daper | VISOL | | | (First, Middle) | e, Maider | n Sumame) | | |
| e, Mar | 1 and 2 sho lealth and lem 27 is m | | 19a. Informant's Name/Relationship (Ty. Judy S. Benser/ Da 20a. Method of Disposition | 2 | 20h PI | | Terrapil | | | | . Mai | or Town, State | 210 | 85 |
| Baltimore, | t. Pages rtment of h rtent: if ite | | 1 Burial 2 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) | , | ce | emetery, crer dar Hi | natory or other p | ery | 11-27 | 7-06 | Balt | _ | | aryland |
| Bal | permi Depar impo impo eny ir | | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or | My Lications that caused th | e death | 1 | Name and Add ICCOMAS I 317 Coke or the mode of the | shurv | Rd. | Abino | rdon. | , Mary | 1 | 21009 Approximate Interval Between |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | Dya to (or as a c | | hence of): | of f | ailar | . (| | | | | Syluni |
| > | ate be executed XX in the hysicien and in the burial-transit and in the burial in the | Ical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a c | consequ | , | iry | Piseu | 11 | | | | 6 | ROYEUVS |
| O. Box 68 | death certific e attending p id for use as t | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown | 3c. If yes, outcome of 1 ☐ Live birth 2 I 4 ☐ Pregnant at tin 9 ☐ Unknown | Fetal | death 3 | Ectopic pregnan | су | | | | 23d. Date of Month | | y Day Year |
| rds, P. | sign sign d be | ۵ | Part II. Other significant conditions cor | ntributing to death but i | not resu | ilting in the u | nderlying cause (| iven in Part I | l. | | | | | e cause of death? |
| | ician: The law requirectificete hes been rector, page 2 should | Completed | | | | | | | | 24a. Wa auto perf 1 □ Yes | s an opsy ormed? 25 No | death | autop to com h? Yes 2 | sy findings available pletion of cause of |
| | Jing Phys After this funeral di | ation: To Be | 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | dospital: 1 Inpatient 28a. Date of Injury (Month, Day Y | | ER/Outpatien 28b. Time of Injury | 28c. In | ther: 45 No | ursing Hor | ne 5 ☐ Res 28d. Describe | idence | | Specify) | |
| <u> </u> | tal or Attand rs after death al Diractor: / | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury building, etc. (| - At ho (Specify | me, farm, str | eet, factory, offic | 9 | 1 | 28f. Location City or To | | | r Rural | Route Number, |
| 1 | To the Hospital or Attano within 24 hours after death To the Funeral Directors completely filled in by the | Medical | 29a Certifier (Check only one) Certifying Physical Examination (Check only one) 2 Medical Examination (Check only one) | ner: On the basis of example and manner state | xaminat | vladge death ion and/or in | vestigation, in my | opinion, dea | ath occurre | and due to the | , date an | d place, and | due to | the cause(s) |
| • | 1358 | | · AK | MD | als (little | 22a) /Tues | D3 | 4652 | - | | Novi | mber | 22 | 2006 |
| 0 | Sta | te | 30. Name and address of per of who conducted the state of | -11 -1 | No | 18/h | Avrage | 131 | 1 11 | Ma | 7/4 | nt | 21 | 914 |
| ŧ | Registr | | NOV 2, 8, 201 | 100 | , d | 1 60 | 3686 | | | | | | | |

| | | | 1 - For State Registrar | State of Maryland / I | | Health and N | Mental Hygi | iene | 37504 |
|-----------|--|----------------|--|---|--|-------------------------------------|--------------------------------------|--|--|
| ı | Physici | | Registrar Decedent's Name (First, Middle, Last) | - C E | EVAN | S | 2. Date of Death Month | h Day, Year | 3. Time of Death |
| | /Medic Examin | | 4a. Facility Name (If not institution, give s | treet and number) | 4b. City, Town, o | or Location of Death | INUVERIOR | 4c. County of De | |
| | LXumm | | Baltimore Washi | ngton Med Ctr | Glen B | urnie | | Anne A | rundel |
| | Funeral Director | | 5. Social Security Number 6. Sex 213-36-6199 Usual Residence of Decedent | 64 00E | rthday) If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, 11/11/ | ^{Year)} 1936 | irthplace (State or Foreign Country) MD |
| | /land | | 10a. State 10b. County | 10c. City, Tow | vn or Location | | | | 10d. Inside City Limits |
| | Many me-1 sh iffed | tor | MD Anne Ar | undel Balt | cimore | | | | 1 ☐ Yes 2, No |
| | death with the Maryland ms 23a or 28a-f show r must be notified at | Director | 10e. Street and Number | | 10f. Zip Code | | 10 | 0g. Citizen of What 0 | Country? |
| | ath w | ral | 121 Bon Air Roa | | 212 | | | U.S.A. | |
| | | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: | 13. Was Decedent of H If Yes, specify Cub | | ecify Yes or No- Rican, etc.) | 14. Race - Am Black, Wh Specify: W | nite, etc. |
| 0-CI2 | within 72 hours after ene. then "natural", or Ite | Completed | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) | College (1-4or 5+) | Decedent's Usual Occup (Give kind of work done life. DO NOT use retire | oation during most of worl d) | ing | 16b. Kind of Busines | s/Industry |
| V | filed wi Hygien other th | Son | 12 | | <u> Technician</u> | 1 | | Social S | ecurity |
| /land | Tbe fill hall He out out | Be | 17. Father's Name (First, Middle, Last) | Errana Cw | | | e (First, Middle, M | | |
| — | hould d Mer marke matic | 7 | James Griffith 19a. Informant's Name/Relationship (Type | | h Mailing Address /Street | | oeth Kr | | Zin Code) |
| 2 | nd 2 sho Ith and 27 ts m traum | | | | b. Mailing Address (Street 21 Bon Air | | | | |
| ē, | s 1 ar f Hea Item other | | 20a. Method of Disposition | 20b. Place o | of Disposition (Name of | | | 20c. Location - City of | |
| Ê | Page nent o nt: If iry or | | 1 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify) | emoval from State | ery, crematory`or other pla clawn Mem | | 22/06 | Marriott | sville, MD |
| saitimore | permit. Pages 1 an Department of Heali Important: If Item 2 any injury or other once. | | 21. Signature of Funeral Service License | | | | | | Home, PA |
| מ | 8858 | | The te | | 169 Rivi | | | | |
| F | Physician /Medical | | A. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) | cations that caused the death. Do e cause on each line. Due to (or as a consequence | can | ng, such as cardiac | or respiratory arre | est, | Approximate Interval Between Onset and Death |
| | Examiner | Jer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury | Due to (or as a consequence | | | | | |
| ,007 | ate be executed hysician and the burial-transit | al Examiner | Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence | of): | | | | |
| | physic the t | 10 | d. | | | | | | |
| Ď . | w requires that the death certificate been signed by the attending phys should be detached for use as the | /sician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown | 3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown | 3 ☐ Ectopic pregnanc 5 ☐ Other (specify) | у | | 23d. Date of d Month | elivery Day Year |
| ds, F. | requires that the een signed by th hould be detache | d by Physi | Part II. Other significant conditions con- | tributing to death but not resulting i | in the underlying cause giv | ven in Part I. | 23e. Did tob | | to the cause of death? |
| Ö | law req as beer 2 shou | lete | | | | | 24a. Was ar | 24b. Were a | autopsy findings available |
| ב | in: The la ificate has or, page 2 | e Completed | 25. Was case referred to medical | | | 00 District David | autopsy perform 1 Yes 2 | prior to death? No 1 Ye | completion of cause of |
| > | Physician: this certific ral director, | 0 8 | examiner? | ospital: 1 Inpatient | utpatient 3□ DOA Ott | nor. | | nce 6 ☐Other (Sp | ecify) |
| 5 | ng Ph ter th | n: T | 27. Manner of Death 1 Natural 5 ☐ Pending | 28a. Date of Injury 28b. | Time of 28c. Injur | | 28d. Describe ho | | |
| SION | eath. or: Ai | catle | 2 Accident investigation | | | Yes 2 □ No | | | |
| | To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At home, fa building, etc. (Specify) | | | City or Town | | |
| | the Hosp hin 24 hou the Fune npletely fil | Aedicai | one) / 2 Medical Examin | ician: To the best of my knowledge er: On the basis of examination are and manner stated. | nd/or investigation, in my o | opinion, death occur | red at the time, da | ite and place, and du | ue to the cause(s) |
| | Vaith Con | W | 29b. Signature and title of certifier | to M | 29c. Licens | _ D3 | 1041 | NoV//7 | 11/1/2006 |
| | 5 | | 30. Name and address of person who cor | 1mmAGA | (Type, Print) | 305 H | to Be | mie! | D21361 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 32 Registrar's Signature | Soule | | | | |

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2 Detect Death

3 Time of Death

| Physician |
|-----------|
| /Medical |
| Examiner |

Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours aftar deeth with the Merylend Department of Health end Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or attanding Physician: The law requiras that tha death certificate be asscuted within 24 hours aftar death.

To the Funeral Director: After this certificate has been signed by the attending physician and complatally filled in by the funeral director, paga 2 should be detached for use as the burial-transit

| | | | | eπ. | ricate of | Deam | | Reg. N | lo. | 20 | 01000 |
|---|---|--|---|----------------|---------------------------------------|---------------------------------------|--|------------|------------------------|------------------------------|--|
| an cal | 1. Decedent's Name (First, Middle, Las Dale_ J FRI | ITTZ | | | | | 2. Dete of Month | | ay a | Year. | 3. Time of Death HAM |
| ner | 4a. Facility Name (If not institution, give | | | | | 4b. City, Town | , or Location of De | | | of Death | a County |
| H | College. Man 5. Social Security Number 6. Se | | last hirthr | day) | If Under 1 Year | | Hrs a Date of | Dieth | | | • |
| | 507-36-0331 | M 2□F 83 | Yrs | "/ | Months Days | | Min. (Month, Aug 8, | Day, Yea | 3 | Count V. | lace (State or Foreign try) A |
| | Usual Residence of Decedent 10a. State 10b. County | 10c. Cit | y, Town o | r Loca | tion | | | | | 10 | Od. Inside City Limits |
| ģ | MD Baltimo | re Ti | moni | .um | | | | | | | 1 ☐ Yes 23€ No |
| Olrec | 10e. Street end Number | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | 10f. Zip Code | | | 10g. C | itizen of | Whet Count | try? |
| le | 129 Hollow Brook | | | | 21093 | | | US | SA | | |
| une | 11. Marital Status | 12. Wes Decedent Ever in U Armed Forces? | S. | 13. Wa If Y | s Decedent of es, specify Cut | Hispenic Origin an, Mexican, P | ? (Specify Yes or Puerto Rican, etc.) | No- | | ce - America ck, White, e | |
| Completed by Funeral Director | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 1 X Yes 2 □ No If Yes, Give Year or Dates: 140 -4 | 18 | 1[| Yes 2⊠ No | Specify: | | | Specif | y: whi | te |
| letec | 15. Decedent's Ed (Specify only highest grad | lucation de completed) | 16a. De | eceder | nt's Usual Occu nd of work done | pation during most of ed) | working | 16b. | Kind of B | usiness/Ind | lustry |
| dmc | Elementary/Secondery (0-12) | College (1-4or 5+) | | | orker | ia) | | bet | hleh | em st | ee1 |
| | 17. Father's Name (First, Middle, Last) | | 110 | , 11 (| OTREI | 18. Mother's | Name (First, Midd | | | | |
| To Be | Mack V. Frittz | | | | | Anna B | ranham R | ogers | S | | |
| | 19a. Informent's Name/Relationship (7 | Type, Print) | 19b. N | ailing | Address (Stree | t and Number o | or Rural Route Nur | nber, City | or Town, | State, Zip | Code) |
| | Doris Frittz/spou | | 129 | Но | llow Br | ook Roa | d Timoni | | | | |
| | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 🖾 Donetion 5 ☐ Other (Specify | Removal from State | emetery, | crema | ion (Name of tory or other pla | ce) | Date | 20c. I | Location - | - City or Tov | wn, State |
| | 21. Signature of Funeral Service Licens Romald S. | Wade Directo | r | St. Ba | Name and Addr ate Ana ltimore | ess of Facility tomy Bo , MD 21 | ard 655 201 | W. Ba | altin | nore S | Street |
| H | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of | plications that caused the deet | n. Do not | | | | | errest, | | | Approximate Intervel Between |
| | | _ | | | | | | | | 1 | Onset end Death |
| | Immediete Cause (Final disease or condition resulting in death) | a. PARK | NS | 01 | V D | SEAS | ·E | | | 1 | byears. |
| Jer | | Due to (d | r as e cor | nseque | ence of): | | | | | | • |
| cami | Sequentially list conditions, | b. — Due to (o | r es e cor | nseque | nce of): | | | | | | |
| a E | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | C | | | | | | | | 1 | |
| Completed by Physician/Medical Examiner | that initrated events resulting in deeth) Last | Due to (o | as a con | seque | nce of): | | | | | | |
| an/N | | d | | | | | | | | | |
| sici | Part II. Other significant conditione co | ontributing to death but not res | ulting in th | ne und | erlying cause g | ven in Part I. | 23b. D | id tobacc | o use co | ntribute to | the cause of death? |
| Y Ph | - SICK Slows | sundrume | | | | | 11 | Yes | 21 No | 3 Prob | ably 4 Unknown |
| pa pa | _ SICK Slaws | 1 2. | _ | | 1 | | 24a. W | es an eut | opsy | 24b. We | re eutopsy findings |
| plet | Intermiter | A HTAIAN | T | 15 | Mat | van | pe | rformed? | | con | ilable prior to apletion of cause leeth? |
| Com | | | | | | | 10 |]Yes a | 2 No | 1 🗆 | lYes 2□ No |
| Be | 25. Was case referred to medical examiner? | Hanakalı | | | | - | Death (Check on) | | | | |
| -T | 1 ☐ Yes 2 ② No 27. Menner of Death | | ER/Outpe 28b. Tim | | 3LI DOA | | ng Home 5 ☐ Re | | | |) |
| tion | 1 Patural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | Inju | | 28c. Inju Wo M 1 | rk? Yes 2 □ No | 28d. Describ | e now inj | ury occur | rea | |
| tifice | 3 ☐ Suicide 6 ☐ Could not be determined | | me, farm | , stree | t, factory, office | | 28f. Location City or 7 | (Street a | and Numb | oer or Rural | Route Number, |
| Cer | | | ^ | | | <u> </u> | | | | | |
| Medical Certification: | 29a. Certifier 1 | yeiclan: To the best of my knowiner: On the basis of examinal and manner stated. | wledge, di ion and/o | eath o | ccurred at the ti stigation, in my | me, date end p opinion, deeth o | lace, and due to the courred at the time | e, date ar | s) and ma nd place, | anner as sta end due to | ited. the cause(s) |
| Σ | 29b. Signature and title of certifier | | | | 29c. Licen | se number | | | | d (Month, E | |
| | A hopez | イグラ | | | DO | 0141 | / | / | 1-1 | 4.1 | 96 |
| | 30. Name and address of person who c | | | | int) | | | | | | |

Coerte

32: Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

NOV 2 8 2006

| | | ŕ | 1 - For State Registrar | State of Marylan | - | artment of H | | - | giene Reg. No.2 () (| 06 3750 | 6 |
|--------------------------------|--|----------------|---|---|---------------------------------|--|---|--|---------------------------------------|---|-----------|
| | Physici | | 1. Decedent's Name (First, Middle, La: Philip Casmir | Ferenc | | | | 2. Date of Dep Month Novembe | Day | Year 006 7:30 A | |
| | /Medio Examir | | 4a. Facility Name (If not institution, given 9600 C Amberleig | h Lane | | | ly Hall | ath | 4c. County | of Death Ultimore | |
| | Funeral Director | | 210-34-3037 | ex 7. Age (In yrs. 70) | last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hi Hours Mi | | y, Year) 936 | 9. Birthplace (State or Fore Country) Maryland | эign |
| | e Maryland Ba-f show | Director | Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo | | y, Town or Lo | erry Hall | ? | | | 10d. Inside City Lim 1 ☐ Yes 2 💆 | |
| | th with the 23a or 23 | | 10e. Street and Number 9600 C Amberle | igh Lane | | 10f. Zip Code | 21128 | | 10g. Citizen of V | What Country? | |
| 980 | within 72 hours after death with the Maryland ena. than "natural", or Itams 23a or 28a-f show I's Mudical Extraillur i ust by tricitind at | by Funerai | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates: | | Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No | spanic Origin? (n, Mexican, Pue Specify: | Specify Yes or No into Rican, etc.) | 14. Race Blac Specify | e - American Indian, ck, White, etc. White | |
| Baltimore, Maryland 21215-0036 | be filed within 72 ho tal Hygiena. Id other than "natu avant, Ire Mi slou | Completed | 15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12) | ducation ide completed) College (1-4or 5+) | (Give | dent's Usual Occupa kind of work done of DO NOT use retired CC Office | luring most of w } | orking | Baltimo | usiness/Industry Ore City Department | |
| yland; | should be filed and Mental Hygid s markad other umatic avant, II | To Be C | 17. Father's Name (First, Middle, Last) Felix Ferenc | | | | | ame (First, Middle, L Kuczyn | | ie) | |
| e, Mar | is 1 and 2 should of Health and Men itam 27 is marks other traumatic | | 19a. Informant's Name/Relationship (Dolores Ferenc 20a. Method of Disposition | (wife) | 9600 | ng Address (Street a | eigh Lar | | Hall, 1 | | |
| Itimor | Pages nent of ant: If i | | 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Licer | sac | red He | sition (Name of matory or other place art of Je 2. Name and Addres | sus 11/ | 25/2006 | Baltimo | re, Maryland | |
| Ba | permit. Departn Imports any init | | グラナ | · | 97 | 105 Belai | r Rd., 1 | 3altimore | , MD 2 | 1236 | |
| | Physician /Medical | | 23a. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | plications that caused the death one cause on each line. End Stage I Due to (or as a conseq | Liver 1 | | g, such as cardi | ac or respiratory ar | rest, | Approximate Interval Between Onset and Death | |
| | Examiner | ner | Sequentially list conditions, and the sequentially list conditions, cause. Enter Underlying Cause (Disease or injury | b. Acute Renal | l Faile | vre | | | | | |
| 8760, 25 | e be executed rsician and e burial-transit | dicai Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. Aspiration Due to (or as a conseq | | onia | | | | | |
| .O. Box 6 | It the death certificate be executed by the attending physician and tached for use as the burial-transit | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown | Ideath 3 | Ectopic pregnancy Other (specify) | | | 23d. Date Mor | e of delivery nth Day Year | |
| rds, P | signed signed d be de | | Part II. Other significant conditions of Alcohol Abuse | ontributing to death but not res | ulting in the u | nderlying cause give | on in Part I. | | | ribute to the cause of death? 3 ☐ Probably 4 🎞 Unkno | |
| Vital Records, | | Completed by | | | | | | 24a. Was autop perfor 1 Yes | rmed? | Were autopsy findings availa prior to completion of cause d death? □ Yes 2□ No | ble of |
| fVit | Physician: Th this certificate ral director, pag | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No | Hospital: 1 ☐ Inpatient 2 ☐ | ER/Outpatien | it 3□ DOA Othe | | eath <i>(Check only o</i> Home 5 X Resid | | er (Specify) | |
| ion of | ttending Ph death. sctor: After th y the funeral | | 27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury Work | | | low injury occurre | | |
| Division | Hospital or Atte | Certification: | 3 Suicide 6 Could not b 4 Homicide determined | 28e. Place of Injury - At ho building, etc. (Specif | ome, farm, str y) | eet, factory, office | | 28f. Location (S City or Tow | Street and Numbern, State) | er or Rural Route Number, | |
| | To the Hospital or within 24 hours after To the Funaral Director completely filled in the completely filled in the completely filled in the fi | edicai | 29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam | ysicien: To the best of my kno niner: On the basis of examina and manner stated. | wledge, death tion and/or in | n occurred at the time vestigation, in my op- | e, date and place sinion, death occ | ce, and due to the courred at the time, | cause(s) and mad date and place, a | nner as stated. and due to the cause(s) | |
| | To the comp | M | 29b. Signature and title of certifier | 2 | | 29c. License | | | | d (Month, Day, Year) | |
| , | .0 | | 30. Name and address of person who | completed cause of death (Iten | n 23a) (Type. | | 59388 | | 11-58 | -06 | |
| | 10 | | David Weisman | 5601 Loch Ro | ver Bli | | none MI | 21239 | | | |
| | Sta Registi | | 31. Date filed (Month, Day, Year) | 32 Registrar's Signa | iture | anti | | | | | |

06-08922 Shirley L. Freeman

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hy

| rilley L. I leen | | 1- For State Registrar | n waryiand / Departn <i>Certifi</i> e | cate of De | | ,, | Reg. No. | |
|--|---------------|---|--|-----------------------|---|--|--------------------------------|--|
| Physici ledical Exam | | Decedent's Name (First, Middle,Last) | | | | 2. Date of Dea | ath 20 | 3 Time of Death |
| nedicai Exam | ner | Shirley L. 4a Facility Name (if not institution, give s | Freeman street and number) | 4b. Ci | ty, Town, or Location | | Day Year er 23, 2006 | 1254 hrs |
| | | 13117 Miles Road | , | | ver Beach | . 504.11 | Baltimore C | |
| Funeral Director | | 5. Social Security Number 6. Sex 1 1 N | 7. Age (In yrs. last b | | Under 1 Year If Und onths Days Hours | | | Birthplace (State or eign Country) MD |
| any | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Tow | n or Location | | | | 10d. Inside City Limits |
| * | ō | MD Baltim | ore | Middle | River | | | 1 Yes 2 X No |
| more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiens and the Health and Mental Hygien are seen it is marked other than "natural", or items 23a or 28a-f she uris. If item 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once | l Director | 10e. Street and Number 13223 Birdale | Avenue | 10f. | Zip Code 21220 | | 10g. Citizen of What C | ountry? |
| death wir r items ? | Funeral | 11. Marital Status 1 Never Married 2 Married | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No | | edent of Hispanic Ori ecify Cuban, Mexicar | gin? (Specify Yes or No n, Puerto Rican, etc.) | White, etc | |
| s after ral", o | by F | 3 Widowed 4 Divorced If | Yes, Give Year | | 2 X No specify | | Specify: Wh | |
| 2 hour | Completed | 15. Decedent's Education (Specify only Elementary/Secondary (0-12) | College (1-4 or 5+) | during most of | ual Occupation (Give working life. DO NOT | | 16b. Kind of Busines | |
| 5-0036 led within 7. Hygiene. other than | dm | 12th | | Cashie | r | | Farm : | Store |
| ID 21215-0036: should be filed within 77 and Mental Hygiene. 77 is marked other than matic event, the Medical | Be Co | 17. Father's Name (First, Middle, Last) | L | | 1 | 's Name (First, Middle, | - ····-, | |
| 212 ould be d Ments s mark ic even | To B | Albert Single 19a Informant's Name/Relationship (Type | e, Print) 1 | 9b. Mailing Addr | ess (Street and Nur | llyn Hild: | tch mber, City or Town, Sta | ate, Zip Code) |
| e, MD 2 1 and 2 shou Health and N item 27 is n | 150 | Dorothy Single 20a Method of Disposition | | | | | | MD 21220 |
| Baltimore, MD permit Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat | | 1 Burial 2 X Cremation 3 | Removal from State crema | atory or other pla | | Date 11/25/06 | 20c. Location - City | i |
| Baltimore permit Pages 1 a Department of H Important: If it injury or other I | | 4 Donation 5 Other Specify: 21 Signature of Furieral Service License | | | ematory and Address of Facilit | | | |
| Ba Perm Dep Dep | | 1111111X1113 KM | 12/10 | | | 300 MACE | e Ave. Ba | lto. MD |
| Physician /Medical | | 3a. Part I. Enter the disease, or compric failure. List only one cause on each | ations that caused the death. Do r | not enter the mo | de of dying, such as o | ardiac or respiratory are | rest, shock, or heart | Approximate Interval Between Onset and |
| Examiner | | Immediate Cause (Final disease or condition resulting in death) | Mixed drug (methado ue to (or as a consequence of): | ne, al ra | zolam, clona | zepsm) intoxi | cation | Death |
| | | Sequentially list conditions, b | | Complicat | пів пурегсеп | sive cardiova | scular diseas | e |
| | Examiner | if any, leading to immediate Ducause. Enter Underlying Cause | ue to (or as a consequence of): | | | | | |
| pa isi | Exan | (Disease or injury that initiated events resulting in death) Last | ue to (or as a consequence of): | | | | | 7 |
| Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed Funeral Director: After this certificate has been signed by the attending physician and rely filled in by the funeral director, page 2 should be detached for use as the burial - trans | | X UNPENDED | AMENDED #00 | | | | | |
| 760, icate be physici the buri | Medical | IF FEMALE: | #23a,PII,26 | <u>,28a-f, p</u> v | erME, g862, | 12/14/06 TT | 23d. Date of deliv- | ery |
| Sox 687 death certifi e attending for use as t | sician/ | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth 4 Pregnant at time of death | 2 Fetal dea | | c pregnancy | Month | Day Year |
| Box e death or the attended for use | Physi | 1 Yes 2 No 9 V Unknown | 9 Unknown | 5 Other (S | pecity) | | | |
| P.O. ss that the gned by e detach | by P | | ontributing to death but not resulti | | ring cause given in Pa | | obacco use contribute | |
| rds, Frequires | | CHIOILE ODSTRUCTIV | ve pulmonary diseas | e | | 1 Ye | | obably 4 Unknown autopsy findings available |
| of Vital Records, ng Physician: The law require this certificate has been simeral director, page 2 should b | Completed | | | | | autor perfo | psy prior to prmed? death? | completion of cause of |
| tal Rection: The certificate | | 25. Was case referred to medical | | | 26.Place of Death | (Check only one) | 2 No 1 | Yes 2 No |
| Vita hysicia this ce | To Be | 1 Yes 2 No | | Outpatient 3 | DOA Other | Nursing Home 5 | Residence 6 🗸 Oth | ner: Scene |
| n of ding Ph | | 27. Manner of Death 1 Natural 5 Pending | (Month, Day, Year) | . Time of Injury | 28c. Injury at Work | | how injury occurred | |
| Division tal or Attendir s after death. al Director: A | ertification: | 2 Accident Investigation | Fnd 11/23/2006 Fnd 28e. Place of Injury - At home, | | н л | UHKHOWH | Street and Number or I | Rural Route Number, City |
| Divisior spital or Attend hours after death neral Director: y filled in by the | i i | 3 Suicide 6 X Could not be determined | (Specify) found in a | | ,, | | State) 13117 Mil. | es Road |
| Di To the Hospital within 24 hours To the Funeral completely filled | calc | 29a Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: 0 | a: To the best of my knowledge, do on the basis of examination and/or | eath occurred at | the time, date and pla | ace, and due to the caus | se(s) and manner as st | arted. |
| To the within 2 To the complet | Medical | 29b. Signature and title of certifier | nd manner stated. | | 29c. License number | curred at the time, date | 29d. Date signed (A | |
| | - | (large 11 | Q 0 0 0 11 | | O.C.M.E. | | November 24, | |
| | } | 30. Name and address of person who cor | npleted cause of death (Item 23a) | | | | <u> </u> | |
| | | | | Penn Stree | t, Baltimore, MD | 21201 | | |
| St Regis | ate trar | 31. Date filed (Month, Clay, Year) NOV 2 8 200 | 32. Redistrar's Signature | South | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 22,2006 **Physician** 2:42 PM WILLIAM JOSEPH FITZPATRICK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month, Day, Vi 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** , reg 908 Months 98 217-09-4401 1 XM 2 ☐ F Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits f show a or 28a-f show t be notified at MD Towson Baltimore 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21286 38 Acorn Circle Apt. 202 ral", or items 23a Examiner must b permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23, any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 【X Married Specify: White 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Deputy Shipping of Baltime Coastal Guard 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katherine Fralinger William Fitzpatrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Acorn Circle Apt. 202-Towson, Maryland 19a. Informant's Name/Relationship (Type. Print) Ruth Fitzpatrick-spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State DRUID RIDGE CEM. 11/27/2006BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility EVANS FUNERAL CHAPEL AND 8800 Harford Road Parkville, Maryland Londrae hTY/3 CREMATION SERVICE 21234 tadol 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tdays /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, If any leading to immuno a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of ician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been sig ; page 2 should b eep venous Thrombosis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 🏋 No 24a. Was an autopsy performe 25 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Yes 2□ No ဥ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 5 ☐ Pending investigation 1 Natural November 7,200 Fellour of Unknow 1 ☐ Yes 2 No wheelchair 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injumy - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Hornicide 38 ACORN CIRCLE, TOWSON,

Box 68760, P.O. Division or Vital Records,

Baltimore, Maryland 21215-0036

Hospital or Attending 124 hours after death.
Funeral Director: After filled in by the within 24

29b. Signature and title of certifier

29c. License number D 58303 w

(Check only one)

2 Medical Examiner: On the basis of rexamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) November 22 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAA(IN) | CHAMMES MM 6565 N. Charles It BAZIMINE MD 2(204) J. Olymnes, Mm 6565

🚝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year) NOV 2 8



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Joseph 13:20 2006 November 26 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Johns Hopkins Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 X M 2 □ F 234-62-0576 66 Director 29, 1940 West Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show 10b. County 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 No West VA Wood Vienna 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 1805 29th Street 26105 <u>USA</u> r than "natural", or Items the Medical Examiner ma 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. filed within 72 hours after ^{2□ No} Korean 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant <u>General Electric</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is marked of Richard Fetty ٩ Emma Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Fetty - Wife 1805 29th Street Vienna, West VA 26105 ce of Disposition (Name of Date 20c. Location - City 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of I Important: If ite any injury or of once, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Nov. 27, 06 Baltimore, MD 21. Signature of Funeral Service Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Parl . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hepatic failure **Physician** disease or condition resulting in death) week /Medical Due to (or as a consequence of) **Examiner** Cardiopulmonary arrest 1 week Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Sepsis Weeks burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Pancreatic Physician/Medical cancer months the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an perform funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 MInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Fafter death. Certification: 5 Pending investigation Injury 1 Natural 1 ∏Yes 2 ∏No neral Director: / 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar NOV 2 8 2006

Bonnie E. Lonze

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES - 000

600 N. Wolfe St

November 26, 2006

Baltimore MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Fabrick Month **Physician** Vincent 3:45 P. M 22, November 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore County Towson Greater Baltimore Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug. 9, Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **X**M 2□ F **Funeral** 1954 52 Director 212-62-8781 Usual Residence of Decedent Peges 1 and 2 should be filed withIn 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Lutherville Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 1625 Bellona Avenue Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married ŏ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes ŽŽNo Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) Landscaping Landscaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 and Mentel h Stanley Fabrick Jean Braithwaite ္က 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tam 27 i 1625 Bellona Avenue, Lutherville, MD 21093 Elsie M. Fabrick 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Pege Depertment of Important: If any injury or once. 11/27/2006 Metro Crematory 4 □Donation 5 □ Other (Specify) Catonsville, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility. Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Artery dis **Physician** Coronary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physic IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by should be 1 Yes 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER Outpatient 3 DOA Medical Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturat 5 T Pending 1 ☐ Yes 2 ☐ No efter death. investigation 2 Accident 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours e peliil Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ţ 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 028266 11/24/06 30. Name and address of derson who completed cause of death (Item 23a) (Type, Print) 5010. YURK Rd, Balto. Mg. 21212 LWIN. M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 8 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc, 16b per fh c861 11-28-06 vt.
State of Maryland / Department of Health and Mental Hygiene amend item 5 per fh g863 : - Certificate of Death 1-16-07 vReg. No. 1. Decedent's Name (First, Middle, Last) Edward 2. Date of Death **Fogler** Month Day Year NOVEMBER >2 2000 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HOSDITAL 18 ONTH WEST BALT MENE CENZON KANDALLETON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 09/Month | Pay | Year | 5. Social Secoty Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1**∑**M 2□F Months 216-09-9790 94 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 1√ Yes 2 No N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2901 FALLSTAFF ROAD #407 21209 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give X 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Warehouse Elementary/Secondary (0-12) College (1-4or 5+) TRAFFIC MANAGER WHAREHOUSE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) **FOGLER** FREDERICK ROSALINE TWELE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2901 FALLSTAFF ROAD #407 - BALTIMORE, MD 21209 BEATRICE FOGLER / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State HILLTOP SERVICE CORP. 11/27/2006 TOWSON, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Furieral Service Licensee 10 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atute MUGORANDIAL Due to (or as a consequence off Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Fa. Cunz 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed

Pnysician /Medical Examiner

attending physician and for use as the burial-translt

ed by the detached

iel or Attending Physician: T s after death. el Director: After this certificat ed in by the funeral director, pa

the Hospitei 24 hours

within 24 P

Physician/Medical

Completed

Be

2

Certification:

Medicai

Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Director

Funeral

à

MD

Funeral

Director

7 is marked other than "natural", or itams 23a or 28e-f show traumatic event, the Medical Examinar must be notified at

the Maryland

hours after

1 end 2 should be filed within Health and Mental Hygiene.

Pages 1 end 2 ment of Health a ent: if item 27 is

permit. Pages Depertment of Importent: If II any injury or conce.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.,

6 Could not be

determined

SiSTASE

Hospital:

2 No

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending investigation

1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ne

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

ORUANDO

29c. License number 18502 29d. Date signed (Month, Day, Year)

MARGLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B

PANSA 115 TOWN

NOVEMBER 22, 2006 Nongower HespiTAL CENTER

State Registrar

31. Date filed (Month, Day, Year) NOV 2 8 2003



and s

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Year 40 **Physician** ster 24 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Baltimore Genesis Eldercare Cromwell Center Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 4, 1924 If Under 1 Year Months Days 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 1 ☑ M 2 ☐ F **Funeral** Pennsylvania 82 188-18-6902 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or frame 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Perry Hall Maryland Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e. Street end Number u. S. A. 5032 Hilltop Acres Rd. 21128 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces?

1 X Yes 2 No 194 11. Marital Status 1 ☐ Never Merried 2 X Married 1942-1 ☐ Yes 2 X No Specify: imore, Maryland 21215-0020 It Yes, Give Year or Dates: Specify: White à 3 Widowed 4 Divorced 1946 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed within 7 Department of Heelth and Mentel Hygiene. Important: if Item 27 is marked other than "ne any injury or other traumatic event, the Media DRCB. Aircraft Equipment College (1-4or 5+) Elementary/Secondary (0-12) Management Years Industrial Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Winovich Samuel Guardino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5032 Hilltop Acres Rd., Perry Hall, Md. 21128 Dorothy Guardino (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 11/22/2006 Baltimore, Maryland 4 □ Donation 5 □ Othe (Specify) Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Paneral Se vice Licensee 9705 Belair Rd., Baltimore, Maryland 21236 6 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Enter the diseas or heart fallure. **Physician** betweethe lungdireare /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner ettending physicien end for use es the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last NSM9C P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed by the injector, page 2 should be deteched 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records, ģ 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 2 X No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) funeral director, 25. Was cese referred to medical Be examiner? Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 21 No Certification: To 2 ER/Outpatient 3□ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Magner of Death 28c. Injury et Work? After 1 Natural 2 Accident 5 Pending To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 106/1901 Ziaz Miran MM 30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

Find Mirra W.D., 6701 W. Charles Ch., Towson,

Registrar DHMH 16 Rev 6/95

10

Zing Mirza MD

NOV 28

2006

31. Date filed (Month, Day, Year)

32 Registrar's Signature

NW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ATT HE State of Maryland / Department of Health and Mental Hygiene 006 37514 For State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1700 2006 014 (-105S U /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Columbia Howard 1 Hospital Howard Count LGEARIT 8. Date of Birth7—13—1944. 9. Birthplace (State or Foreign (Manth, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1**⊠**M 2□ F Yrs. -42-1753 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28e-f show any Injury or other traumatic event, the Machical Exprision must be notified at once. Baltimore 1 ☐ Yes 2 ☑ No Bultimore MO Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 USA 32 F Road tock Mill Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No 1f Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Specify: Black 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) r1500 Correctional 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 904g 10401 (2005S 19a. Informant's Name/Relationship (Tyre, 19b. Mail Address (Street and Number or Rura Route Number, City or Town, State, Zip Code) oma 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State itmore, 06 * 4 □ Donation 5 □ Other (Specify) 21. Signatur of Fune al Service License of Gipeene 21133 Approximate Interval Between Onset and Death 23a. Part1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 16/21/9 /Medical Due to (or as a consequence of) Examiner 14 e1056 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy ned by the atten Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 2 No certificate 1 TYes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Cher (Specify) 2 SER/Outpatient 3 □ DOA ဥ 1⊠Yes 2 No 1 Inpatient this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; Injury 1 Natural 5 Pending investigation 1 Tyes 2 🗀 No death. after death 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 Thomicide within 24 hours a completely filled 1 Creatifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D Leda 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 6-30 PM NOV 2006 ANDREW GRACE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner tealth Baltimore If Under 1 Year If Under 24 Hrs. enesis are 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 108 M 2□ F Yrs. Director 428-34-1496 01/09/1930 76 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 ☑ No resville Battimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UR. 1200 C 21208 Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married by 1 1 ☐ Yes 2 🗷 No Specify: 3 ₩idowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Post GED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be) essie Grace Varcissie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mora (daughter) 1200 Valley Country C+ Apt. Pikesville, HD 21208 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 월 Burial 2 ☐ Cremation 3 ☐ Removal from State Doodkun Cemeter 11/25/2006 4 ☐ Donation 5 ☐ Other (Specify) Battimore, MD 22. Name and Address of Facility Youghn C Greene Funeral SVC SISP Batte Wat Pike Batt more, MD 21229 21. Signature of Funeral Service Licensee augho (Treene 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 04 TONSIL MALIGNANT NEOPLASM Month disease or condition resulting in death) Due to (or as a consequence of): CAILURE THRIVE 70 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Striknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

Physician /Medical Examiner anding physicien and use as the burial-transit Division of Vital Records. P.O. Box 68760. certificate has been signed by the erector, page 2 should be deteched After this certific funeral director, this within 24 hours efter des To the Funeral Directo

the Maryland

or 28a-f ahow

27 is marked other than "natural", or Itema 23s or traumatic avant, the Medical Examinar must be a

Pages 1 end 2 should be filed within 72 hours efter on the file and Mental Hygiene.

Baltimore, Maryland 21215-0036

investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

JECertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Dey, Year) D0053110 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO GUPTA 0 BOX 6303 21042 Shawwaran 31. Date filed (Month, Day, Year) 32 Registrar's Signature

State Registrar

Medical

NOV 28 2006

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.0.6

| | | For State Registrar | State of Ma | ırylar | nd / Depa | artment of F | lealth and N Death | Mental Hy | ygiené Reg. No | | 37516 |
|--|------------------|--|---|------------------|---------------------------------|--|---|-------------------------------------|-------------------|-----------------------------------|--|
| Physicia | | 1. Decedent's Name (First, Middle Antonio Jose G | | | | | | 2. Date of D | eath Da | 19 2006 | 3. Time of Death 1020 P M |
| /Medic Examin | | 4a. Facility Name (If not institution, | | | | 4b. City, Town, o | or Location of Death | - De an | | . County of Death | |
| | | Upper Chesapeak | | | | Bel A | | | | Harford | |
| Funeral Director | | 5. Social Security Number 356-44-8051 Usuaf Residence of Decedent | 6. Sex 7. Age 1 ★ 2 F | 6 (In yrs. 55 | last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of B (Month, D Feb. 1 | 7, 1 | 951 Puer | place (State or Foreign ntry) to Rico |
| rland ow | 1 | 10a. State 10b. County | - | 10c. Ci | ty, Town or Lo | ocation | | | | | 10d. fnside City Limits |
| death with the Maryland me 23a or 28a-f ehow me 11 | Director | Maryland Harfo | ord | E | dgewoo | d. 10f. Zip Code | | | 10g. Cit | tizen of What Cou | 1 □ Yes 2√2 No ntry? |
| h with | aiDi | 1914 Eloise Lar | ne | | | 2104 | 10 | | USA | | |
| | Funeral | 11. Marital Status 1 □ Never Married 2 ★ Married | 12. Was Decedent E Armed Forces? | | J.S. 13. | | dispanic Origin? (Sp an, Mexican, Puerto | ecfy Yes or No Rican, etc.) | 10- | 14. Race - Ameri Black, White, | |
| 1215-0036 within 72 hours after an an an antical Examples to the Medical Examples | ted by | 3 ☐ Widowed 4 ☐ Divorced 15. Decedent | | | 16a Dece | 1 Yes 2 No | Puer | to Rica | | Specify: Whi | |
| vithin 7 | Completed | (Specify only highes Elementary/Secondary (0-12) | College (1-4or 5- | +) | | | during most of work d) | | Do | akaaina | |
| High variation of the strain o | | 17. Father's Name (First, Middle, I | Last) | | Snipp | ing/kecei | iving Cle: 18. Mother's Nam | | | ckaging | |
| yland | To Be | Rufino (unk) | Garcia | | | | Marina | (unk) | (unk | :) | |
| a sha | | 19a. Informant's Name/Relationsh Rosalyn Garcia/ | | | 1.5000000 | 1 7595 LY | and Number or Rui | | | | |
| es 1 and 2 of Health of Health flem 27 | | 20a. Method of Disposition 1 □ Burial 2 □ Cremation | 3 □Removal from State | 20b. | Place of Dispo cemetery, cre | osition (Name of matory or other pla | сө) | Date | | ocation - City or To | |
| Bartimo permit. Pages Department of Important: If it eny Injury or o | | 4 Donation 5 Other (St. 21. Signature of Funeral Service I | pecify) | Hi | | | Corp. 11- | | | son, Mar | yland |
| Ba Perm Dependent Impo | | 21. Signatur II Princial Solvice C | | | | | uneral Ho sbury Rd. | | | Marailan | .a. 21000 |
| Physician /Medical Examiner | | 23a. Part Enter the disease, or shock, or heart failure. List of Immediate Cause (Finaf disease or condition resulting in death) | complications that caused only one cause on each lin a. Cutluct Due to (or as a | aler | th. Do not en | ter the mode of dyii | ng, such as cardiac | or respiratory | arrest, | 1 | Approximate Interval Between Onset and Death |
| 3760, ate be executed hysician and he burial-transit | I Examiner | Sequentially fist conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a | | | | | | | | |
| 687 687 flicate t | dical | | d. | | | | | | | | |
| Records, P.O. Box 68 The law requires thet the death certifica stee has been signed by the ettending ph page 2 should be detached for use as th | by Physician/Med | fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 Fet | al death 3[| □Ectopic pregnanc □ Other (specify) _ | у | | | 23d. Date of deliv Month | ery Day Year |
| dS, P. | by Pt | Part II. Other significant condition | ns contributing to death bu | ut not re | sulting in the t | inderlying cause giv | ven in Part I. | 23e. Dio | Itobacco | use contribute to t | the cause of death? |
| Cording w require | | - Wine | | | | | | 1 🗆 | Yes 2 | No 3□Prol | babły 4 ∐Unknown |
| / = %- | Completed | | | | | | | | opsy formed? | prior to co | opsy findings available ompletion of cause of No |
| Nital F | Be | 25. Was case referred to medical examiner? | Hospital: | \ | <i>(</i> | l Ott | 26. Pface of Dear | | | | |
| Phys or this sral di | ı: To | 1 Yes 2 No 27. Manner of Death | 28a, Date of fniur | v . | ER/Outpatie | III 3 DOA | 4 Nursing H | ome 5 ☐ Re. 28d. Describe | _ | 6 ☐Other (Specially occurred | (y) |
| ision of islanding Photosic After the funeral | atlor | 1 Natural 5 ☐ Pending 2 ☐ Accident investig | | / Year) | Injury | | rk?]Yes 2 □No | | | | |
| Divis Divis al or Atte | Certification; | 3 Suicide 6 Could r 4 Homicide determine | | ry - At h | nome, farm, st | reet, factory, office | | | (Street ar | nd Number or Run e) | al Route Number, |
| Division Division to the Hospital or Attensiting to the Funce alter deel for the Funceral Director: completely filled in by the | Medical C | | g Physician: To the best of Examiner: On the basis of and manner sta | examin | | | | | | | |
| To the within 2 To the comple | Me | 29b Signature and title of certifier | 11 | | | 29c. Licens | | | | ate signed (Month, | |
| | | Donald de | MA MI, INE | | | 400 | 4206 | | Nore | ender Zi | 2 2006 |
| 9. | | 30. Name and address of person DERMARD YUL | who completed cause of de | eath (Ite | m 23a) (Type 16/4 C | Renchost. | 4206 le Nd. Be | lai 1 | 1160 | 2015 | |
| Sta | | 31. Date filed (Month, Day, Year) | 32. Registra | ar's Sign | ature | resident of the second | | | | | |

| | | | State 1- State Registr Amend #19a Per Ir | | | | lealth and M Death | | -2006 | 37517 |
|---------------------------------|--|----------------|---|-------------------------------------|------------------------------------|---|--|--|---|--|
| | \$400 A | ¥ | Decedent's Name (First, Middle, Last) | ц gooz I | 2/04/90 | minimate or | Death | 2. Date of Death | | 3. Time of Death |
| 9 | Physici /Medio | | Harriet Margaret | Glenn | | | | Month Novembe | Day Year r 22, 200 | |
| 185. 361. | Examir | | 4a. Facility Name (If not institution, give street and | i number) | | 4b. City, Town, o | r Location of Death | | 4c. County of De | |
| | | | 201 B Crocker Drive | 7 Ann //n | in a hint in | Bel Ai | | 0.000 | Harford | |
| П | Funeral Director | | 5. Social Security Number 6. Sex 1 M 2 🔀 | 7. Age (In yrs. | 90 Yrs. | Months Days | Hours Min. | 8. Date of Birth (Month, Day, | Year) 9. 8 | irthplace (State or Foreign Country) |
| 2. | ס | | Usual Residence of Decedent | | 90 | | | Aug. 9, | 1916 Ma | ryland |
| | anylan how | b., | 10a. State 10b. County | 10c. C | ity, Town or Lo | cation | | | | 10d. Inside City Limits |
| | 189-1 | Directo | Maryland Harford | Be | l Air | | | | | 1 <mark>▼</mark> Yes 2 No |
| | with the sor 2 | D | 10e. Street and Number | | | 10f. Zip Code | | | g. Citizen of What (| Country? |
| | ns 23 | Funeral | 201 B Crocker Drive 11. Marital Status 12. Was | Decedent Ever in U | J.S. 13. V | 21014 Vas Decedent of H | lispanic Origin? (Spe | | JSA 14. Race - An | nerican Indian. |
| 9 | or iter | | 1 Never Married 21 Married 1 □ Y | d Forces? es 2⊠No | ŧ | | dispanic Origin? (Spe an, Mexican, Puerto i | Rican, etc.) | Black, Wh | |
| 93 | filed within 72 hours after death with the Maryland Hygiene. tither than "natural", or items 23a or 28e-1 ehow inth, the Medical Exama ar must be routified at | d by | | , Give or Dates: | | ☐ Yes 2½ No | Specify: | | Specify: W | hite |
| 21215-0036 | "nati | Completed | 15. Decedent's Education (Specify only highest grade completed) | ted) | (Give | lent's Usual Occup kind of work done DO NOT use retired | during most of workii | ng 1 | 6b. Kind of Busines | s/Industry |
| 7 | within lene. | dwc | Elementary/Secondary (0-12) College | ge (1-4or 5+) | Homem | | -/ | | Own Home | |
| | itled Hyg other | BeC | 17. Father's Name (First, Middle, Last) | | HORE | MICE. | 18. Mother's Name | (First, Middle, Ma | | |
| /lar | uld be Menta vrked vrked | To B | Charles Edward Whi | te | | | Harriet | Myrtle | Fink | |
| Maryland | 2 sho and is mu | | 19a. Informant's Name/Relationship (Type, Print) | | | | and Number or Rura | | - | |
| ≥ o` | 1 and Health Im 27 Ther tu | 1 3 | Richard Green / Son 20a. Method of Disposition | | | Quecbec | School Ro | The state of the s | | |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or items 23s or 28e-f ehow any injury or other traumatic event, the Medical Exams are must be notified at ance. | | Burial 2 ☐ Cremation 3 ☐ Removal for | rom State | cemetery, cren | f Faith (| ce) | _ | Oc. Location - City o | |
| 를 | artme ortent injury | ı | 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Lice (See | / | | | | | заттшюте | , Maryland |
| æ | Den Gen Van Van | | I houles of man | | | | ss of Facility Hon | | Jon Marri | land 21009 |
| 177114 | | | 23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause | at caused the dea | th. Do not ente | er the mode of dyir | ng, such as cardiac o | r respiratory arres | icit, Mary | Approximate Interval Between |
| | Physician | | termodiate Course (Final) | | | | | | | Onset and Death |
| 1.3 | /Medical Examiner | | resulting in death) | Y PERT | quence of): | | | | | |
| | LXammer | _ | Sequentially list conditions, b. | HEROSC | | sis | | | | |
| | nsit | nlne | cause. Enter Underlying Cause (Disease or injury | 10 (0: as a consec | querice or). | | | | | |
| Ć | execu In and ial-tra | Examiner | that initiated events c. resulting in death) Last Due | to (or as a consec | quence of); | | | | | |
| 68760, | ficate be executed g physician and is the burial-transit | edical | d | . <u></u> | | | | | | |
| _ | - m m | Med | IF FEMALE: | | | | | | | |
| Вох | eath certifi ettending I for use as | lan/ | 23b. Was decedent pregnant in the past 12 months? | outcome of pregn ve birth 2 Peta | al death 3 🗌 | Ectopic pregnancy | , | | 23d. Date of d | elivery Day Year |
| o. | The faw requires that the death cert sie has been signed by the ettending page 2 should be detached for use | Physician/M | | regnant at time of on nknown | jeath 5∐ | Other (specify) | | | | |
| <u>a</u> | s that ned b | by Pr | Part II. Other significant conditions contributing | to death but not res | sulting in the un | derlying cause giv | en in Part I. | 23e. Did toba | cco use contribute | to the cause of death? |
| g | equire en sig | ed b | | | | | | 1 ☐ Yes | 2 2 No 3 ☐ F | Probably 4 Unknown |
| 000 | e taw re has bev | Completed | | | | | | 24a. Was an autopsy | 24b. Were a | autopsy findings available completion of cause of |
| œ | The cete h | Con | | | | | | performe | ed? death? | |
| Vita | iclen: certific ector, | Be | 25. Was case referred to medical examiner? | | | 04 | 26. Place of Death | / | | |
| o | Phys | - T | T Tes 20000 | ☐ Inpatient 2 ☐ ate of Injury | ER/Outpatient 28b. Time of | | 4 Nuising Hon | ne 5 Residen 8d. Describe how | | ecify) |
| Division of Vital Records, P.O. | Attending Physicien: r death. ector: After this certification in the funeral director. | Certification: | 1 ☑Natural 5 ☐ Pending (1 2 ☐ Accident investigation | Month, Day Year) | Injury | 28c. Injur Wor M 1 | k? Yes 2 □No | od. Describe from | injury occurred | |
| N S | Atter | He | 3 Suicide 6 Could not be 28e. P | lace of Injury - At h | ome, farm, stre | et, factory, office | 2 | 8f. Location (Stre | et and Number or F | Rural Route Number, |
| | ital or A rs after rai Dire | Cer | | unding, etc. (Special | ·y) | | | City or Town, | 314(0) | |
| | To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page. | edical | 29a. Certifier (Check only one) 1 VCertifying Physician: To | ne basis of examina | owledge, death ation and/or inv | occurred at the tin | ne, date and place, a pinion, death occurre | nd due to the cau d at the time, dat | se(s) and manner a e and place, and du | s stated. e to the cause(s) |
| | o the ithin 2 o the omple | Med | 29b. Signature and title of certifier | nanner stated. | | 29c. Licens | e number | 290 | f. Date signed (Mor | ith, Dav. Year) |
| | - 5 - 5 | | 1// [[[[]]]] | | | | 5921 | | | , |
| (| 51 | } | 30. Name and address of person who completed | cause of death (Iter | n 23a) (Type, F | | | 10. | UVE TO BER | 27, 2006 |
| | U | | 2227 OLD EMMOR | TON RD | SUITE | = ZII | Mahmood | MARYL | AND 211 | 215 |
| 9 | Sta Registr | | Si di | 2. Registrar's Signa | ature | M. a | | | | |
| O. | negisti | 41 | NOV 2 8 2006 40 | salar S. | See See | | | | | |

| | | | | Please | e Type or Prin | | | | | - | | - | |
|--------------------------------|--|-------------------|---|------------------------------------|--|--------------------|--|---|---------------------|--|-------------------------|---|--|
| | | | For State Registrar | | | aryland | | artment of F rtificate of | | nd Mental Hy | giene Reg. No | 0000 | 37518 |
| į | Physici /Medic | | 1. Decedent's Name (Norman | | Last) | | , Gregoi | c | | 2. Date of De Month Novemb | Da | y Year 22, 2006 | 3. Time of Death 4:25 A M |
| | Examin Funeral Director | | 4a. Facility Name (If n 7156 Ohi 5. Social Security Nur 219–28–588 | o Avenu | | e (In yrs. k 72 | ast birthday) Yrs. | 4b. City, Town, of Hanove If Under 1 Year Months Days | er If Under 24 | Death | th ay, Year) | Anne Art | th |
| | Maryland a-f show ifled at | tor | | Decedent 10b. County Anne Ar | undel | | , Town or Lo | | | DCC.TC | 19172 | | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No |
| | th with the 23a or 28. Ist be not | al Director | 10e. Street and Numb | | | | | 10f. Zip Code 21076 | | | | izen of What Co | ountry? |
| 900 | be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 ☐Never Married 3 ☐ Widowed 4 | | 12. Was Decedent Armed Forces? 1 Yes 2 1 Yes, Give Year or Dates: | | | Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No | | n? (Specify Yes or No Puerto Rican, etc.) | >- | 14. Race - Ame Black, Whit Specify: W | te, etc. |
| 215-0 | ithin 72 hd ne. nan "natu Medical | Completed | (Specify Elementary/Second | | Education grade completed) College (1-4or 5 | i+) | (Give life. | dent's Usual Occu kind of work done DO NOT use retire | during most o d) | of working | 16b. K | ind of Business | /Industry |
| nd 21 | be filed wil tal Hygien d other th: event, the | Be | 12 17. Father's Name (F | | est) | | Cril | Attenda | 18. Mother's | s Name (First, Middle | , Maiden | General Surname) | Motors |
| laryla | 2 should and Mer is marke aumatic | Ը | Max Greg 19a. Informant's Nam | ne/Relationship | , ,, | | 19b. Mailii | ng Address (Street | | Rose Con or Rural Route Numb | | or Town, State, | Zip Code) |
| Baltimore, Maryland 21215-0036 | es 1 and of Healtl f Item 27 r other t | | Mrs. Eile 20a. Method of Dispo | sition | gor / Wife □Removal from State | CE | ace of Dispo | osition (Name of matory or other pla | ce) N | nover MD 2 ov. 27, | | ocation - City or | Town, State |
| 3altim | permit. Pag Department Important: I any injury o | | 4 □ Donation 5 | 5 □ Other (<i>Spe</i> | cify) | - | (4)(| lge Mem. | ess of Facility | 2006 Singletor | Fur | cridge, neral Ho | ome, P.A. |
| | 40 2 6 6 | | 23a. Panti. Entir he shock, or heart | e disease, or co | emplications that caused aly one cause on each lin | | | | | SW Glen I | | ie, MD 2 | Approximate Interval Between |
| | Physician /Medical | | Immediate Cause (Fi disease or condition resulting in death) | | a. Due to (or as | wille | Can | erz | | | | | Onset and Death Amouths |
| | Examiner | iner | Sequentially list cond if any, leading to imm cause. Enter oncome Cause (Disease or in | ditions, nediate | b. Due to (or as | a consequ | ence of): | | | | | | |
| 38760, | ficate be executed physician and s the burial-transit | dical Examiner | that initiated events resulting in death) La | | cDue to (or as | a consequ | ence of): | | | | | | |
| P.O. Box 687 | ath certi | Physician/Medical | IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown | nonths? | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown | 2 Fetal | death 3 | ⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _ | у | | | 23d. Date of de Month | livery Day Year |
| rds, P | w requires that the de been signed by the s should be detached to | by | Part II. Other signific | cant conditions | s contributing to death be | ut not resu | lting in the u | nderlying cause giv | ven in Part I. | | | A | o the cause of death? |
| Vital Records, | | Completed | 25. Was case referre | and to modical | | | | | | 1□ Yes | psy ormed? 2 D No | prior to death? | utopsy findings available completion of cause of |
| Division or Vi | ng Phy (fter this Ineral d | ation: To Be | examiner? 1 Yes 2 2 2 2 2 2 2 2 2 2 | 5 Pending investigat | | ry | ER/Outpatier 28b. Time o Injury | f 28c. Inju | ner: 4 □ Nurs | 28d. Describe | dence | 6 □Other (Spe | icity) |
| Ď N | ital or Att rs after de ral Direct led in by t | Certification: | 3 ☐ Suicide 4 ☐ Homicide | 6 □ Could not determine | building, etc. | c. (Specify |) | reet, factory, office | | City or To | wn, State | e) | ural Route Number, |
| | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu | l edical | (Check only 2 one) | 2 | Physician: To the best caminer: On the basis of and manner sta | f examinat | vled g e, deat ion and/or in | vestigation, in my | opinion, death | place, and due to the occurred at the time | , date an | d place, and du | e to the cause(s) |
| | wit oor | M | 29b. Signature and ti | K his | 16 mb | | | D'38 | | | | te signed (Moni | th, Day, Year) |
| | 10 | | Nicholas I | Koutrea | kos 111065 | Litt | le Pat | | rkway (| Columbia M | D 21 | 044 | |
| | Sta Registr | | 31, Date filed (Month | OV 28 | 2006 32 Registra | ars Signat | F A | randi) | | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 23, 2006 Vincent P. Garafalo, Jr. 7:27 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Months Hours Min. 76 Director August 18, 1930 216-24-2915 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural" or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Marvland Baltimore Parkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1324 Rayville Road 21120 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Korea If #es, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status I and 2 should be filed within 72 hours after dealth and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐XNo Specify. à Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Foreman Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vincent P. Garafalo, Sr. Anna Foxwell Starvakos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michele Cimino/Daughter 1324 Rayville Road Parkton, Maryland 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 🗓 Other (Specify) Entombment Gardens of Faith Cem. 11/28/06 Baltimore Maryland 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death -Obstructive Pulmonar Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Other significant conditions ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes Other: 10 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation 1 Tes 2 □ No Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. Charles St/ Boot aulknermo 31. Date filed (Month, Day, 32. Registrar's Signature Year)

DHMH 17 Rev 1/2001

Registrar

NOV 2 8 2006

06-08872 Please Type or Print in Black Indelible Ink Danielle Kristen Gerati State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day November 21, 2006 **Medical Examiner** Danielle Kristen Geraci 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 13614 Colgate Way #448 Silver Spring Montgomery 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or oreign Director Months Days Hours Min 071-68-2441 2 X F 23 October 24, 1983 1 M Country) New York Usual Residence of Decedent è 10a State 10c. City, Town or Location 28a-f show items 23a or 28a-f shoust be notified at once. Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Montgomery Rockville Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 13614 Colgate Way, Apt. 448 20904 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married White etc. Yes 2 X No 3 Widowed Divorced If Yes, Give Year Yes 2 X No specify or other traumatic event, the Medical Examiner Specify White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 4 Student Schoo1 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Richard Geraci Donna Geanne Barbato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna G. Geraci/mother 20454 Afternoon Lane, Germantown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, November Baltimore, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 28, 2006 mportant 4 Donation 5 Other Specify Montgomery Crematorium Bethesda, Maryland 21. Signature of Funeral Service Licep 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc William a. Olnes 300 W. Montgomery Avenue, Rockville, Maryland 20850 Part I Enter the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical a Saddle Pulmonary Thromboembolism Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last burial - tran and Physician/Medical X UNPENDED AMENDED perMF. 12/16/06 TT ttending physir use as the bu 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed' death? ✓ Yes 2 No 1 V Yes 25. Was case referred to medical 26.Ptace of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Pendina

1144 hrs

10d. tnside City Limits

1 Yes 2 X No

Approximate Interval

Between Onset and

Death

Year

28f. Location (Street and Number or Rural Route Number, City

November 22, 2006

29d. Date signed (Month, Day, Year)

or Town, State)

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director:

2

3

4

29b.

Medical

State

Registrar

Accident

Suicide

Homicide 29a Certifier 1 (Check only one) 2

Signature

Susan Hogan MD.

31. Date filed (Month, Pax)

Investigation

Could not be

determined

30. Name and address of person who completed cause of death (Item 23a)

200

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

L

DHMH 17 Rev 1/2001 OCME 2006

28e. Place of tnjury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 24 2006 **Physician** 4:23 A M GABER **ELLEN** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A 7121 PARK HEIGHTS AVENUE #502 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/31/1931 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 1 □ M 2 🔽 F 75 MD 214-30-3087 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1**Y**Yes 2□No Director MD BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7121 PARK HEIGHTS AVENUE #502 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, GiveX Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No WHITE Baltimore, Maryland 21215-0036 þ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PROPERTY OWNER REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked MILTON **SCHWABER CECELIA** SAKOLSKY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau MARR / COMPANION 7121 PARK HEIGHTS AVENUE #502 - BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 F Donation 5 Other (Specify) ¢HIZUK AMUNO CONG. 11/26/2006 BALTIMORE, MD 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. 21. Signature A Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1/Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** netastatic years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Otner (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performe 2 No certificate 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation neral Director: A filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours To the Funeral 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

NOV

ddress of person who completed cause of death (Item 23a) (Type, Print) Gaber

32. Registrar's Signature

D

Year)

2 8 29c. License number

D23964

29d. Date signed (Month, Day, Year)

Sucte 445 1878 Greenettee Pal Balto Md.

| | | 1 - For State Registrar | State of Marylan | | ent of F | Health and I | - | | 2006 | 37523 |
|--|---------------------|--|---|--|--|---|-------------------|---|------------------------------|---|
| | | Registrar Decedent's Name (First, Middle, Last) | | Ocitino | ale or | Douth | 2. Date of De | | | 3. Time of Death |
| Physicia /Medica | _ | Dolores Mary | Hetterick | | | | Month | Day 22 | 06 | 1:30 PM |
| Examine | | 4a. Facility Name (If not institution, give st | | 4b. | | or Location of Deatl | n | 4c. | County of Deal | h |
| Funeral Director | | 5. Social Security Number 6. Sex 212-42-8436 | M 20XF 62 | | Inder 1 Year oths Days | If Under 24 Hrs. Hours Min. | 8. Date of Bi | rth ay, Year) | 9. Bin 944 M | hplace (State or Foreign buntry) aryland |
| 9 | | Usual Residence of Decedent 10a. State 10b. County | | y, Town or Location | 1 | | Morcoit | | | 10d. Inside City Limits |
| e Maryla | ctor | Maryland Balti | | | Notti | ngham | | | | 1 ☐ Yes 2 No |
| it es | Dire | 10e. Street and Number | | 10 | f. Zip Code | | | | izen of What Co | |
| Sath v | era | 8905 Carlisle Aven | LUC 2. Was Decedent Ever in U. | S 13 Was F | | 1236 | nacify Vac or N | | U. S. A 14. Race - Ame | |
| re, Maryland 21215-0036 s 1 end 2 should be filed within 72 hours after death with the Maryland freety and Mariat Highen. Heelit and Mariat Highen. Item 27 is marked other then "netural", or items 23s or 28s-1 show other treumatic event, the Medical Examinar must be mutified. | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | | specify Cub | Hispanic Origin? (S an, Mexican, Puerl Specify: | to Rican, etc.) | | Black, Whit | |
| 21215-0036 21215-0036 od within 72 hours att ggiene. i. the Medical Exerti | Completed | 15. Decedent's Educ (Specify only highest grade | completed) | 16a. Decedent's (Give kind of life. DO No | Usual Occup of work done OT use retire | during most of wo | rking | 16b. K | ind of Business | Industry |
| 272 Jiene. | E O | Elementary/Secondary (0-12) 12th Grade | College (1-4or 5+) | | Homemo | aker | | | Own Ho | me |
| Pd 20 | Be C | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nar | ne (First, Middle | e, Maiden | Sumame) | |
| larylan | 2 | Gordon Miles | | | | Mary | Hersel | | | |
| Maryland Maryland Shuld be filed and Mental Hyg 27 is marked other renamatic event, | | 19a. Informant's Name/Relationship (Typ | | 1 | | and Number or Re | | | | |
| The set | | Tom Hetterick (Hus | | | | e Ave., A | lottingn Date | | Marykan ocation - City or | |
| Baltimore, semit. Pages 1 er Depertment of Hee mportant: If tem eny Injury or other | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re | | Place of Disposition emetery, crematory Joseph | | | | | | |
| Baltimol permit. Pages Depertment of Important: If I eny Injury or once. | | 4 Donation 5 Other (Specify) 21. Signature of Fundia Service List asset | | | | ess of Facility So | | | | |
| Balt permit. Depentingord Import | J | Am Olyman | M. | 9705 | Bela | ir Road, | Baltimo | re. | Marylan | d 21236 |
| Physician / Medical Examiner of principle of | Examiner | 23 . Part1 Enter the disease, or complication fock, or heart failure. List only on limited late Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence to (or as a consequence) | uence of): | aili 8Cin | LICE . | unor. | | | Approximate Interval Between Onset and Death |
| 76(te be ysicie | Ca | L _d | | | | | | <u>.</u> | | |
| of Vital Records, P.O. Box 68' Physicien: The law requires that the death certificat r this cartificate has been signed by the eltending phy ral director, page 2 should be detached for use es th | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown | Ideath 3⊟Ecto | pic pregnanc ar (specify) _ | у | | | 23d. Date of de Month | ivery Day Year |
| Cords, P.O. wrequires that the deben signed by the should be detached | þ | Part II. Other significant conditions con | tributing to death but not res | ulting in the underly | ring cause gr | ven in Part I. | | tobacco (| | o the cause of death? |
| Division of Vital Records, tor Attending Physicien: The law requires teller death. Director: Alier this certificate has been signe in by the funeral director, page 2 should be of the by the funeral director. | Completed | | | | | | perf | s an opsy formed? 2 \(\sqrt{No} | prior to death? | utopsy findings available completion of cause of 2 No |
| f Vital F yeicien: Th is certificete director, pag | Be | 25. Was case referred to medical examiner? | ospital: | Irno: | Jac. Off | 26. Place of De | | | • De:: := | 10.1 |
| Phys r this srat di | : To | 1 ☐ Yes 2 ☑ No ☐ | 28a. Date of Injury | 28b. Time of | 28c. Inju | ry at | lome 5 Res | | | cify) |
| Vision of Attending Phy or death. ector: After thi by the funeral c | il or | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day Year) | Injury N | Wo | rk?]Yes 2.∐No | | | | |
| Division selfor Attendi | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At he building, etc. (Special | | actory, office | | | (Street and own, State | | ural Route Number, |
| | Medical (| | ician: To the best of my kno er: On the basis of examina and manner stated. | | | | | | | |
| To the within To the comp | ž | 29b. Signature and title of certifier | 1 : 11 | MA | | se number | | | te signed (Mont | |
| | | O trant | colles. | 1.1.7. | 700 | 5 666.3 | | | 11 | 22/2006 RE, MD 212 |
| 12 | | 30. Name and address of person who con | mpleted cause of death (Iter | n 23a) (Type, Print) | | | | _ | | |
| | | DR. Stuart. R. 31. Date filed (Month, Day, Year) | 32. Registrar's Signa | 000 41 | Rank | 1.10 Sq | uare dr | -Bo | altimo | RE MD 212 |
| Stat Registra | | | 32. Hegistrar's Signal | is final | ELS. | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** George John Hammerbacher, Sr. 25, November 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye April 19, 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Year) 1 M 2 □ F 215-10-4173 90 1916 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 U.S.A. 231 Woods Way Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Western Electric permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, <u>If</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John George Hammerbacher Bertha Elizabeth Falkenhan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Rugemer (daughter) 231 Woods Way, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/29/2006 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** meriosdera pas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the lirector, page 2 s 1∏ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence Other (Specify) | HOSPICE Hospital: 1 ☐ Yes 2 No ဥ this 27. Manner of Lath 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: il or Attending Fafter death. 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: , 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year,

State Registra Year)

DHMH 17 Rev 1/2001

6601 N. Charles Street

(Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary G. Hughes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT AGNES HOSPITAL LAMORE n/a 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 17, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛣 F Months Hours 212-05-1982 90 Director 1916 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other then "natural, or items 23a or 28a-f shovent, the Medical Examiner must be notified at Director MD Baltimore 1 ☐ Yes 2√ No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Ln. - HV323 USA Completed by Funeral 21228 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after cent of Health and Mental Hygiene.
ant: if item 27 is marked other then "natural; or ites
any or other traumatic event, the Medical Experimen. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify Specify. 3 XWidowed 4 ☐ Divorced white white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph M. Guerin ၉ Caroline S. Tippett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any injury or other trai Thomas Hughes - Son 2228 Malraux Drive Vienna, VA 22182 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Nov. 24, 06 Baltimore, MD 22. Name and Address of Facility
Cremation Society of Maryland, 1116.
299 frederick Road Baltimore, MD 21228
Approximate Interval Between Onset and Death 22. Name and Address of Facility
Cremation Society of Maryland, Inc. 21. Signature of uneral Service License 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) THEROSCLEROTIC **Physician** DISEASE YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and is the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day 4 Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ LYMPHOCYTIC CHRONIC LE UKEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an After this certificete has autopsy perform 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours efter death To the Funeral Director: , completely filled in by the f 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) the Left 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 74 MEDICAL DOCTOR P20805 NOVEMBER 23 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 KWAME NTIM 900 CATON AVE BALTIMORE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Jana Co Registrar NOV 2 8 2006

| | 1 | For State Registrar | State Of | Marylan | | eparime Certifica | | | and ME | | Reg. No. | 2008 | 37 | 529 |
|--|--|---|---|---|--|--|--|--|--|--|--|--|--|--|
| * | | Registrar Decedent's Name (First, Middle, La | ast) | | | , cr timoc | | Dourn | 2 | 2. Date of Dea | - Bay | 000 | 3. Time o | |
| ysician | į. | Agnes Parson Hov | , | | | | | | | Month Nov. | 21 Day | 2006 Year | 8:05 | A M |
| Medical | | 4a. Facility Name (If not institution, give | | nber) | | 4b. Cit | y, Town, o | r Location o | | 110 4 1 | | ounty of Dea | | |
| aminer | ı | Stella Maris | | | | Tin | noniu | m | | | I | 3altim | ore | |
| eral | | 5. Social Security Number 6. | | 7. Age (In yrs. | last birth | day) If Und | er 1 Year s Days | If Under 2 | 24 Hrs. 8 Min. | B. Date of Birt (Month, Da) | h y, Year) | 9. Bi | rthplace (State | or Foreign |
| ctor | | 407-44-3423 | 1□M 2□F | 75 | Yr | s. | | | - | | 1 193 | 30 T | N | |
| | - 1- | Usual Residence of Decedent 10a. State 10b. County | | 10c. Cit | v. Town o | or Location | | | | | | | 10d. Inside C | City Limits |
| of at | - 1 | | | | | | | | | | | | 1 √Yes | 2 □ No |
| be notified Director | ב ב | TN Coffee | e | | Tull | ahoma | Zip Code | | | | 10g. Citize | en of What C | 122 | |
| t be | | 507 Twelve Oaks | Rd. | | | : | | 388 | | | | | USA | |
| iner must | 2 | 11. Marital Status | | edent Ever in U | .S. | 13. Was De | cedent of H | lispanic Orig | gin? (Spec | ify Yes or No | . 14 | | erican Indian, | |
| Fur | | 1 ☐ Never Married 2 ☐ Married | Armed For | X□ No | | | 2₩ No | an, Mexicar Specify: | i, rueilo n | iican, etc.) | | Black, Wh | | |
| Exam | 2 | 3 X Widowed 4 ☐ Divorced | If Yes, Giv Year or Da | ates: | | 1 103 | X | ореспу. | | | | Specify: | white | |
| t, the Medical E | 100 | 15. Decedent's E (Specify only highest gr | | | 1 6 | ecedent's U Give kind of | work done | during most | t of workin | g | 16b. Kin | d of Busines: | s/Industry | |
| m D | 2 | Elementary/Secondary (0-12) | College (1 | -4or 5+) | 1 ' | ife. DO NOT | | a) | | | 0 | | 4- | |
| å Ö | | 12 17. Father's Name (<i>First, Middle, Las</i> | n/a | | 1 | Secre | tary_ | 18. Mothe | er's Name | (First, Middle, | | overnm Surname) | ent | |
| even | | Paul Parson | ,,, | | | | | | | Aylor | | , | | |
| To | 2 | 19a. Informant's Name/Relationship | (Type Print) | | 19b. I | Mailing Addre | ess (Street | L | | Route Numb | | Town, State, | Zip Code) | |
| trani | | | (1), p. 0. 1 | | 1 | _ | • | | | aris, | | | | |
| other | + | Joel Shaw/son | | 20b. | Place of D | Disposition (I | vame of | | | ate | | | or Town, State | |
| y or | | Burial 2 Cremation 3 | | State | - | - | | | | | | | | |
| | - 1 | | CITVV | - IUai | c Law | m Cem | etery | | 11/24 | ·/06 | Dunc | dalk, | MD | |
| | | | | Ual | C Law | | and Addre | ess of Facilit | ty | | | | | |
| eny injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director | | 21. Signature of Furthers Service Lice | ensee | Ual | K Law | 22. Name | and Addre | ess of Facilit | ty Home | of Dul | aney | Valle | y, Inc. | |
| one injur | | 21. Symature of Funda Service Lico Lowell M. Let 23a Part 1 Enter the disease, or co | mmon_ | aused the dea | | 22. Name Lemmo | and Addre n Fun Pado | ess of Facilities of Facilitie | ty Home dT | of Dul | aney m. M | Valle | y, Inc. | etween |
| | | 21. Signature of Funda Service Lice Lowell M. Let 23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final | mmon_mplications that cly one cause on e | caused the dea | th. Do no | 22. Name Lemmo 10 W | and Addre n Fun Pado | ess of Facilities of Facilitie | ty Home dT | of Dul | aney m. M | Valle | y, Inc. | etween |
| cian | | 21. Signature of Fundata Service Lice Lowell M. Let 23a. Part1. Enter the disease, or conshock, or heart failure. List only | mmon mplications that cly one cause on e | aused the dea | th. Do no | 22. Name Lemmo 10 W ot enter the n | and Addre n Fun Pado | ess of Facilities of Facilitie | ty Home dT | of Dul | aney m. M | Valle | y, Inc. | etween |
| cian | | 21. Simature of Funda Service Lice Lowell M. Let 23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) | mmon mplications that cly one cause on e | caused the dea | th. Do no | 22. Name Lemmo 10 W ot enter the n | and Addre n Fun Pado | ess of Facilities of Facilitie | ty Home dT | of Dul | aney m. M | Valle | y, Inc. | etween |
| cian tical tiner | ner | 21. Simature of Funda Service Lice Lowell M. Let 23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | mmon mplications that coly one cause on e a. MULT Due to | caused the dea | th. Do no | 22. Name Lemmo: 10 W. ot enter the n | and Addre n Fun Pado | ess of Facilities of Facilitie | ty Home dT | of Dul | aney m. M | Valle | y, Inc. | etween |
| cian tical tiner | aminer | 21. Synature of Fundage Service Lice Lowell M. Let 23a. Part1. Enter the disease, or conshock, or heart failure. List onli Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | mmon mplications that color y one cause on e a. MULT Due to to b. Due to | aused the dea each line. IPLE MY (or as a consection of the conse | ELOM. quence of | 22. Name Lemmo: 10 W. ot enter the n | and Addre n Fun Pado | ess of Facilities of Facilitie | ty Home dT | of Dul | aney m. M | Valle | y, Inc. | etween |
| cian dical diner | Examin | 21. Signature of Fundata Service Lice Lowell M. Let 23a. Partt. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | mmon mplications that color y one cause on e a. MULT Due to to b. Due to | caused the dealeach line. | ELOM. quence of | 22. Name Lemmo: 10 W. ot enter the n | and Addre n Fun Pado | ess of Facilities of Facilitie | ty Home dT | of Dul | aney m. M | Valle | y, Inc. | etween |
| cian dical diner | Examin | 21. Synature of Fundage Service Lice Lowell M. Let 23a. Part1. Enter the disease, or conshock, or heart failure. List onli Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | mmon mplications that color y one cause on e a. MULT Due to to b. Due to | aused the dea each line. IPLE MY (or as a consection of the conse | ELOM. quence of | 22. Name Lemmo: 10 W. ot enter the n | and Addre n Fun Pado | ess of Facilities of Facilitie | ty Home dT | of Dul | aney m. M | Valle | y, Inc. | etween |
| cian dical diner | Examin | 21. Synature of Fundage Service Lice Lowell M. Let 23a. Part1. Enter the disease, or conshock, or heart failure. List onli Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | mmon mplications that c ly one cause on e a. MULT Due to b. Due to c. Due to | caused the dea rach line. IPLE MY (or as a consection of the con | ELOM. Quence of | 22. Name Lemmo: 10 W. ot enter the n | and Addre n Fun Pado | ess of Facilities of Facilitie | ty Home dT | of Dul | aney MI | Valle D 2109 | y, Inc. Approximinerval Bronset and | etween |
| cian dical diner | Examin | 21. Synature of Fundal Service Lice Lowell M. Let 23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant | mmon mplications that c ly one cause on e a. MULT Due to b. Due to c. Due to d | caused the dealeach line. IPLE MY (or as a consector as a consec | ELOM quence of quence of quence of anancy at death | 22. Name Lemmo: 10 W. ot enter the n A): | and Addre | ess of Facilities of Facilitie | ty Home dT | of Dul | aney MI | Valle | y, Inc. Approximinerval Bronset and | etween |
| for use as the burial-transit control of the burial-transit control of the burial-transit control of the burial-transit control of the burial-transition of the burial-tran | Examin | 21. Simature of Fundata Service Lice Lowell M. Let 23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 KNo | mmon mplications that c ly one cause on e a. MULT Due to b. Due to c. Due to d | caused the dea each line. IPLE MY (or as a consector as a consec | ELOM quence of quence of quence of anancy at death | 22. Name Lemmo: 10 W. ot enter the n | and Addre | ess of Facilities of Facilitie | ty Home dT | of Dul | aney MI | Valle D 2109 | y, Inc. Approxim Interval B. Onset and | etween d Death |
| for use as the burial-transit control of the burial-transit control of the burial-transit control of the burial-transit control of the burial-transition of the burial-tran | Physician/Medical Examin | 21. Simature of Fundra Service Lice Lowell M. Let 23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | mmon mplications that c ly one cause on e a. MULT Due to b. Due to c. Due to d. 23c. If yes, out 1 □ Live t 4 □ Pregr 9 □ Unkn | caused the deal aach line. IPLE MY (or as a consection of a consection of as a consection of | FLOM quence of q | 22. Name Lemmo 10 W. ot enter the n A): 3 □ Ectopi 5 □ Other | and Address n Fun Pado node of dyi | ess of Facilities of Facilitie | ty Home d., T | of Dullimoniu | aney m MI | Valle D 2109 | y, Inc. Approxim Interval B. Onset and | Year |
| be detached for use as the burial-transit up to the burial-transit by Dhycsician/Medical Examiner | by Physician/Medical Examin | 21. Simature of Fundata Service Lice Lowell M. Let 23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 KNo | mmon mplications that c ly one cause on e a. MULT Due to b. Due to c. Due to d. 23c. If yes, out 1 □ Live t 4 □ Pregr 9 □ Unkn | caused the deal aach line. IPLE MY (or as a consection of a consection of as a consection of | FLOM quence of q | 22. Name Lemmo 10 W. ot enter the n A): | and Address n Fun Pado node of dyi | ess of Facilities of Facilitie | ty Home d., T | of Dullimonium respiratory a | aney m. MI | Valle D 2109 3d. Date of c Month | y, Inc. Approximination of the control of the cont | Year |
| be detached for use as the burial-transit up to the burial-transit by Dhycsician/Medical Examiner | by Physician/Medical Examin | 21. Simature of Fundra Service Lice Lowell M. Let 23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | mmon mplications that c ly one cause on e a. MULT Due to b. Due to c. Due to d. 23c. If yes, out 1 □ Live t 4 □ Pregr 9 □ Unkn | caused the deal aach line. IPLE MY (or as a consection of a consection of as a consection of | FLOM quence of q | 22. Name Lemmo 10 W. ot enter the n A): | and Address n Fun Pado node of dyi | ess of Facilities of Facilitie | ty Home d., T | of Dullimonium respiratory a | aney m MI rrest, | Valle D 2109 3d. Date of a Month | y, Inc. Approximination of the cause of the | Year f death? QUnknow |
| ishould be detached for use as the burial-transit up of the burial-transit up of the burial-transit up of the burial-transit up of the burial | by Physician/Medical Examin | 21. Simature of Fundra Service Lice Lowell M. Let 23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | mmon mplications that c ly one cause on e a. MULT Due to b. Due to c. Due to d. 23c. If yes, out 1 □ Live t 4 □ Pregr 9 □ Unkn | caused the deal aach line. IPLE MY (or as a consection of a consection of as a consection of | FLOM quence of q | 22. Name Lemmo 10 W. ot enter the n A): | and Address n Fun Pado node of dyi | ess of Facilities of Facilitie | ty Home d., T | of Dullimonium respiratory a 23e. Did 1 24a. Was auto | aney m MI rrest. | Valle D 2109 3d. Date of c Month se contribute No 3 24b. Were prior t death | y, Inc. Approximation of the cause of the c | Year I death? Unknows availab |
| page 2 should be detached for use as the burial-transit or o | Completed by Physician/Medical Examin | 21. Simature of Fundate Service Lice Lowell M. Let 23a. Partt. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions | mmon mplications that c ly one cause on e a. MULT Due to b. Due to c. Due to d. 23c. If yes, out 1 □ Live t 4 □ Pregr 9 □ Unkn | caused the deal aach line. IPLE MY (or as a consection of a consection of as a consection of | FLOM quence of q | 22. Name Lemmo 10 W. ot enter the n A): | and Address n Fun Pado node of dyi | ess of Facilities of Facilitie | ty Home d., T | of Dullimonium respiratory a 23e. Did 1 1 24a. Was auto perfit 1 Yes | aney m MI rrest, 22 tobacco us Yes 2 an psy ormed? 2 No | Valle D 2109 3d. Date of o Month se contribute No 3 24b. Were prior t | y, Inc. Approximation of the cause of the c | Year I death? Unknows availab |
| page 2 should be detached for use as the burial-transit or use us the burial-transit or use use the burial-transit or use use the burial-transit or use the burial transition of the burial transition or use the burial transition of the burial transition or use the burial transi | Be Completed by Physician/Medical Examin | 21. Simature of Fundate Service Lice 23a. Part1. Enter the disease, or conshock, or heart failure. List onlimmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions | mmon mplications that c ly one cause on e a. MULT Due to b. Due to c. Due to d. 23c. If yes, out 1 □ Live t 4 □ Pregr 9 □ Unkn s contributing to d | caused the deal aach line. IPLE MY (or as a consect (or as a consect tcome pf pregribith 2 Fet nant at time of lown) eath but not re | FLOM quence of quence of anancy al death death sulting in | 22. Name Lemmo 10 W. ot enter the n A): 3 □Ectopi 5 □ Other the underlyin | and Address Pado Pado c pregnanc (specify) g cause gi | ess of Facilities and I are all and I are all and I are all and I are all are | ty Home d - , T cardiac or | of Dullimonium respiratory a 23e. Did 1 1 24a. Was auto perfect of the control of | aney MI rrest, 2: tobacco us Yes 2 an psy primed? 2 X No | Valle D 2109 3d. Date of of Month se contribute No 3 □ 24b. Were prior to death 1 □ Yo | Approximinterval Bionset and onset a | Year f death? [Unknow s availab cause of |
| al director, page 2 should be detached for use as the burial-transit a p p a director, page 2 should be detached for use as the burial-transit To Bo Completed by Dhysician/Madical Fyaminer | To Be Completed by Physician/Medical Examin | 21. Signature of Further Service Lice 23a. Part1. Enter the disease, or consolone, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | mmon mplications that c ly one cause on e a. MULT Due to b. Due to c. Due to d | caused the dealeach line. IPLE MY (or as a consection of a consection o | ELOM. quence of quence of quence of salting in ER/Out 28b. Ti | 22. Name Lemmo 10 W. ot enter the n A): 3 □Ectopi 5 □ Other the underlyin patient 3 □ ime of | and Address Pado C pregnance (specify) g cause gi | ess of Facilities of Facilitie | Home d - T cardiac or | of Dullimonium respiratory a 23e. Did 1 1 24a. Was auto perfit 1 Yes | aney MI rrest, 2: tobacco us Yes 2 an psy prmed? 2 \overline{X} No one) idence 6 | Valle D 2109 3d. Date of a Month se contribute No 3 □ 24b. Were prior t death 1 □ Yo | Approximinterval Bionset and onset a | Year f death? [Unknow s availab cause of |
| neral director, page 2 should be detached for use as the burial-transit a p p use to be Completed by Dhysician/Medical Examiner | To Be Completed by Physician/Medical Examin | 21. Signature of Further Service Lice 23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending | mmon mplications that c ly one cause on e a. MULT Due to b. Due to c. Due to d. 23c. If yes, our 1 Live 4 Pregr 9 Unkn s contributing to d | caused the deal aach line. IPLE MY (or as a consect (or as a consect (or as a consect the consect that it is a consect to come pf pregraphint 2 Fet mant at time of cown leath but not resulting the consect that it is a | ELOM. quence of quence of quence of salting in ER/Out 28b. Ti | 22. Name Lemmo 10 W. ot enter the n A): 3 □Ectopi 5 □ Other the underlyin | c pregnanc (specify) g cause gi | ess of Facilities of Facilitie | Home d - T cardiac or | 23e. Did 1 24a. Was auto perfer 1 Yes (Check only one 5 Res | aney MI rrest, 2: tobacco us Yes 2 an psy prmed? 2 \overline{X} No one) idence 6 | Valle D 2109 3d. Date of a Month se contribute No 3 □ 24b. Were prior t death 1 □ Yo | Approximinterval Bionset and onset a | Year f death? [Unknow s availab cause of |
| neral director, page 2 should be detached for use as the burial-transit a p p use to be Completed by Dhysician/Medical Examiner | To Be Completed by Physician/Medical Examin | 21. Simature of Fundra Service Lice 23a. Part1. Enter the disease, or conshock, or heart failure. List onlimmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | mmon mplications that coly one cause on ely one cause on ele a. MULT Due to b. Due to color c. Due to color d. 23c. If yes, out color color color d. 23c. If yes, out color | caused the dealer and line. IPLE MY (or as a consection of a cons | ELOM quence of quence of quence of anancy al death death sulting in | 22. Name Lemmo 10 W. ot enter the n A 3 □ Ectopi 5 □ Other the underlyin patient 3 □ ime of jury M | c pregnanc (specify) | ess of Facilities and a Remail Remail Remail Remail Remail Remails Rem | Home d . T cardiac or | 23e. Did 1 24a. Was auto perfu yes. (Check only one 5 Res. Res. Describe | aney MI rrest, 2: tobacco us Yes 2 an psy pred? 2 Mo one) idence 6 how injury | Valle D 2109 3d. Date of a Month se contribute No 3 24b. Were prior t death 1 Y occurred | Approximinterval Bionset and onset a | Year f death? [Unknow] s availab cause of |
| neral director, page 2 should be detached for use as the burial-transit a p p use to be Completed by Dhysician/Medical Examiner | To Be Completed by Physician/Medical Examin | 21. Sinature of Further Service Lice 23a. Part1. Enter the disease, or consolone, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | mmon mplications that coly one cause on ely one cause on ele a. MULT Due to b. Due to color c. Due to color d. 23c. If yes, out color color color d. 23c. If yes, out color | caused the dealeach line. IPLE MY (or as a consection of the dealeach line). (or as a consection of the dealeach line). Inpatient 2 Inp | ELOM quence of quence of quence of anancy al death death sulting in | 22. Name Lemmo 10 W. ot enter the n A 3 □ Ectopi 5 □ Other the underlyin patient 3 □ ime of jury M | c pregnanc (specify) | ess of Facilities and a Remail Remail Remail Remail Remail Remails Rem | Home d . T cardiac or | 23e. Did 1 24a. Was auto perfu yes. (Check only one 5 Res. Res. Describe | aney MI rrest, 2: tobacco us Yes 2[an psy 2 M No one) idence 6 how injury | Valle D 2109 3d. Date of a Month se contribute No 3 24b. Were prior t death 1 Y occurred | Approximinterval Bonset and Onset an | Year f death? [Unknow] s availab cause of |
| neral director, page 2 should be detached for use as the burial-transit a p p use to be Completed by Dhysician/Medical Examiner | Certification: To Be Completed by Physician/Medical Examin | 21. Signature of Further Service Lice 23a. Part1. Enter the disease, or consolidate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XNo 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death 1 Natural 5 Pending investigation of the pending investigation | mmon mplications that c ly one cause on e a. MULT Due to b. Due to c. Due to d. 23c. If yes, out 1 Live t 4 Pregr 9 Unkn s contributing to d Hospital: 1 28a. Date (Mor. and a be build) Physician: To the | caused the dealeach line. IPLE MY (or as a consection of | ELOM quence of q | 22. Name Lemmo 10 W. ot enter the n A): 3 Ectopi 5 Other the underlyin me of jury M m, street, fac | c pregnanc (specify) DOA Ot 28c. Inju Wc 1 Etory, officerred at the | ess of Facilitie eral linia Ring, such as 26. Place ther: 4 North North Part I liny at ork? Yes 2 time, date a | Home d., T cardiac or services and place, an | 23e. Did 1 24a. Was auto perfect of 1 Yes. (Check only one 5 Res. 28d. Describe 28f. Location (City or To | aney m MI rrest, 22 tobacco us Yes 2 an psy ormed? 2 No one) idence 6 how injury (Street anc wn, State) | Valle D 2109 3d. Date of of Month se contribute No 3 24b. Were prior to dear to dea | Approximination of the cause of | Year f death? QUnknov s availab cause o |
| led in by the funeral director, page 2 should be detached for use as the burial-transit application. To Be Completed by Dhysician/Medical Framiner | To Be Completed by Physician/Medical Examin | 21. Signature of Further Service Lice 23a. Part1. Enter the disease, or consolidate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XNo 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death 1 Natural 5 Pending investigation of the pending investigation | mmon mplications that c ly one cause on e a. MULT Due to b. Due to c. Due to d. 23c. If yes, out 1 □ leve 4 | caused the dealeach line. IPLE MY (or as a consection of | ELOM quence of q | 22. Name Lemmo 10 W. ot enter the n A): 3 Ectopi 5 Other the underlyin me of jury M m, street, fac | c pregnanc (specify) DOA Ot 28c. Inju Wc 1 Etory, officerred at the | ess of Facilitie eral linia Ring, such as 26. Place ther: 4 North North Part I liny at ork? Yes 2 time, date a | Home d., T cardiac or services and place, an | 23e. Did 1 24a. Was auto perfect of 1 Yes. (Check only one 5 Res. 28d. Describe 28f. Location (City or To | aney m MI rrest, 22 tobacco us Yes 2 an psy ormed? 2 No one) idence 6 how injury (Street anc wn, State) | Valle D 2109 3d. Date of of Month se contribute No 3 24b. Were prior to dear to dea | Approximination of the cause of | Year f death? QUnknow s availab cause of SPIC. |

State

DR. TARIO MAHMOOD
31. Date filed (Month H34 Neg) 8 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

2300 JULANEY VALLEY RD. 06 32. Registrar's Signature

43725

TIMONIUM, MD 21093

11/21/06

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Muriel Hinzman 8:50 A^M November 15,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 202Scott's Manor Drive Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 X F Director 92 219-05-1846 Sept. 15, 1914 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature". 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 Scott's Manor Drive 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify. Specify: White Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Trexler Carrie Vogel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Janice Colbert/ Daughter 202 Scott's Manor Drive Glen Burnie MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 17, Nov. 4 Donation 5 Other (Specify) Meadowridge Mem. 2006 Elkridge, MD 22. Name and Address of Facility Singleton Funeral Home, 21. Signature of Funeral Service Licenses 191 Second Avenue SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (evel) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. the attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9□Unknown 9 Unknown been signed by ta should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 000 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 **□** Certification: To After this 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Dooth 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) November, 15, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Runse mel 2106 2 Per 31. Date filed (Month, Day, Year) 2. Registrar State s Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** JOANN HARMAN 8:00 Ам 11 23 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Washington Medical Ctr. Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year)
May 27,1936 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) **Funeral** Days Hours 70 212-34-4484 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show or Items 23a or 28a-f shov miner must be notified at MD 1 ☐ Yes 2 No Funeral Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1304 Eleanore Drive 21061 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. other traumatic event, the Medical Examiner e filed within 72 hours after of Hygiene "Holisten", or Itel 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 1 □ Yes 2√CXNo Specify Completed by Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Nurse's Aid 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be Roy Frank Kopp 2 Valda Singer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miss Kathleen Harman/daughter 1810 Ridgewick Road, Glen Burnie MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Department of Important: If It any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/28/2006 Elkridge, MD Meadowridge Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Fun ral Service/Lic 22. Name and Address of Facility Singleton Funeral Home P.A. M01364 1 Second Ave SW Glen Burnie MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line? th as cardiac or reserratory arrest. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner an mary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last for use as the burial-trai Due to (or as a conse prence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 T Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ₩ → 24a. Was an autopsy performed 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 ☐ Inpatient 3 🗆 DOA the funeral 27. Manner Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 milatural 5 Pending investigation M 1 ☐ Yes 2 🗆 No death. 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner state 29b. Signature and title of certifier 29d. Date signer (Month, Day, Year) 20094 0 completed gause of death (Item 23a) Type, Print) 10

State

31. Date filed (Month, Day,

Year)

8

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Yolanda Heckmann 11/23/2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1751 Forrest Avenue Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Director 215-24-8167 84 07/26/1922 Mary land Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at 1 TYes 2XINo Directo MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1751 Forrest Avenue 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. Specify: White 3 X Widowed 4 Divorced Completed injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Joseph Paciarelli Josephine Piacentini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Carol Mehring, Daughter</u> 17 Cardinal Road, Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Moreland Memorial Park 11/28/2006 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc any llizandva 5305 Harford RD. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one caus used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate ha 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only ope) examiner? 1 Yes 2016 Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No ours after death.
neral Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier Medical CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 0020176 30. Name and address of

State

Registrar

31. Date filed (Month,

NOV 28

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** November 22,2006 HOOVER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Rockville Montgomery tosp Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 5, 1951 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday **Funeral** Months 1⊠M 2□F 55 215-60-8328 Washington, D.C. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1XIYes 2□No Rockville Director Marvland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 United States 39 Eton Overlook 'natural", or Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23: any Injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Government Quality Assurance Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Ross Hoover Rowena Apsel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39 Eton Overlook, Rockville, Maryland 20850 Mira Yang Hoover/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 1, 1 Burial 2 □ Cremation 3 □ Removal from State Norbeck Memorial Park Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2006 22. Name and Address of Facility Robert A. Pumphrey Funeral home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue M01473 Bethesda, Maryland 20814 21. Signature of Funeral Senfice Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): -Zda7 /Medical Examiner 1040Mag. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Box 68760. certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2.3 autopsy moken 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 | Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

W

State Registrar 31. Date filed (Month, Day,

Ledical Conter Dr. Brockelle, MAD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

06-08855 Natalie Hanna

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Year **Medical Examiner** 1518 hrs November 20, 2006 Natalie Hanna 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10290 Connecticut Avenue Kensington Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months Days Hours Min Director Country) Minnesota 215-92-6105 1 M 2XXF 43 Yrs 1962 21 Dec. Usual Residence of Decedent any 10b. County 10c. City, Town or Location 10d Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the M dieal Examiner must be notified at once. 1 Yes 2 XXNo Maryland Montgomery death with the Maryland Director Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10290 Connecticut Avenue, 20895 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 White, etc. Married 2 X No Yes Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. 3 Widowed 4 Divorced if Yes, Give Year Yes 2 X No specify: Specify: **Black** ş or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DD NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 4 Accountant Administration 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Edgar E. Hanna, Jr. Norma J. Rushen 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma J. Hanna/Mother 3333 Gold Mine Road, Brookeville, MD 20833 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State November 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Norbeck Memorial 28, 2006 Olney, Maryland Park 22. Name and Address of Facility o ert . umpi rey luneral lome, Mol473 Rockville, Inc. 300 West Montgomery Avenue M01473 Rockville, Maryland 20850-2805 4 Donation 5 Other Specify. 21. Sign ure of Funeral Servi de icensee Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillure. List only one it use on each line. Physician Approximate Interval Between Onset and /Medical Death Immediate Cause (Final disease Acute asthmatic attack Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Physician/Medical X UNPENDED signed by the attending physician i be detached for use as the burial -AMENDED #23a,27,perME, g862, 12/21/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 ✔ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been s funeral director, page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 V Yes 2 27. Manner of Death 28a. Date of Injury (Month, Day,Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Director: Pending 1 Yes 2 No 2 Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Suicide Could not be or Town, State) determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.F. November 22, 2006 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, th, Day, Year) 32. Re istrar's Signature State Registrar

DHML E E E E E C

| | | | State of Maryland / I | | rtment of He | | ental Hygier | / ! ! ! ! | 6 37532 | | |
|---------------------|--|---|--|--|--|--|-------------------------------------|----------------------------------|---|--|--|
| | Physicia | an | 1. Decedent's Name (First, Middle, Last) | | | | 2. Date of Death Month 11/17/2 | nth Day Year | | | |
| , | /Medic | al | Bernard James Heilman 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or Lo | | 4c. County of | | | | |
| | Examin | | 2 Sunset Circle | | Pasadena | | | Anne A | Arundel | | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last bi | irthday) | If Under 1 Year | f Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Ye | ar) 9 |). Birthplace (State or Foreign Country) | | |
| | Director | | 212-54-9876 ¹ M ^{2□} F 57 | Yrs. | World's Days | 10010 | 04/10/1 | 949 | MD | | |
| | pu * | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow | wn or Loc | cation | | | | 10d. Inside City Limits | | |
| | Aaryla f •ho | 5 | MD Anne Arundel Pasa | ader | na | | | | 1 ☐ Yes 2 ☑ No | | |
| | the 28a- | rect | 10e. Street and Number | | 10f. Zip Code | | 10g. | Citizen of Wh | at Country? | | |
| | h with | a D | 2 Sunset Circle | | 21122 | | | U.S.A | • | | |
| | deat | ner | 11. Marital Status 12. Was Decedent Ever in U.S. | 13. V | Vas Decedent of Hisp Yes, specify Cuban, | anic Origin? (Spe Mexican, Puerto I | cify Yes or No- Rican, etc.) | | American Indian, White, etc. | | |
| 36 | or its | by Funeral Director | 1 Never Married 2 Married 1 Yes 2 No 1969 | - | ☐ Yes 2 No. | | | Specify: | White | | |
| Ö | hours tural | q pe | | a. Deced | ent's Usual Occupation | on | 166 | . Kind of Busi | | | |
| 5 | within 72 hours after death with the Maryland sne. Then "natural", or items 23a or 28a-f ehow na Mooical Examiner must be nutified at | Completed | (Specify only highest grade completed) | (Give life. C | kind of work done dui OO NOT use retired) | ring most of worki | ng | | ŕ | | |
| 212 | d with | mo: | | Mecl | nanic | | | Const | ruction | | |
| b | al Hyg | BeC | 17. Father's Name (First, Middle, Last) | | | | (First, Middle, Mai | | | | |
| <u>yla</u> | 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene and Mental Hygiene is in marked other then "natural, or items 23a or 28a-f show is marked other then "natural, or items 23a or 28a-f show raumatic event, the Modical Examinator must be notified at | To | Albert Raymond Heilman, Sr. | | | | th Boyd | | 7 0 4 0 1 0 6 1 | | |
| Maryland 21215-0036 | 12 sh h and h and 7 ie m traum | 7 | | | g Address <i>(Street</i> and Dak Mano | | | | Burnie, MD | | |
| e, | 1 and Healt em 2 | | 20a Method of Disposition 20b. Place | of Dispos | sition (Name of | | | | ity or Town, State | | |
| Baltimore, | permit. Pages 1 and 2 should b Department of Health and Mentic Importent: if Item 27 is marked ent injury or other traumatic a <u>once.</u> | | 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State | - | natory`or other place) rans Cem | | 2/06 C | rowns | ville, MD | | |
| ቜ | nit. P ertme orten injur | | 21. Signature of Funeral Service Licensee | | | | | | al Home, PA | | |
| ã | Deperming of the permit of the permit with the permit of t | | Feed In | 1 | 69 Rivie | ra Driv | re, Pasa | dena, | MD 21122 | | |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. | not ente | er the mode of dying, | such as cardiac c | r respiratory arrest, | | Approximate Interval Between Onset and Death | | |
| 4 | Physician /Medical Examiner | Immediate Cause (Final disease or condition Hyperensive Caldiovalum d | | | | | | disease | | | |
| | | | resulting in death) Du to or as a consequence | | | | | | | | |
| | Х | _ | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence | e of): | | | | | | | |
| 14 | red nsit | Examiner | cause. Enter Underlying Cause (Disease or injury | , . | | | | | | | |
| , | execu n and ial-tra | Exai | that initiated events c. resulting in death) Last Due to (or as a consequence | e of): | | | | | | | |
| 8760, | law requires that the death certificate be executed as been signed by the ettending physicien and 2 should be detached for use as the buriat-transit | cai | | | | | | | | | |
| 89 | ng ph | | IF FEMALE: | | | | | | | | |
| Вох | eath certific ettending pl | Physician/Med | 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat | | Ectopic pregnancy Other (specify) | | | 23d. Date of delivery Month Day | | | |
| <u>.</u> | the e | ysic | 1 Yes 2 No 9 Unknown | | | | | | | | |
| P.O. | ires that the de signed by the e i be detached f | H. | Part II. Other significant conditions contributing to death but not resulting | 23e. Did tobacco use contribute to the cause of death? | | | | | | | |
| sp | quires n sign | d by | | | | | 1 ☐ Yes | 2 □ No 3 | Probably nknown | | |
| Records, | aw requir ss been si 2 should | Completed | | | | | 24a. Was an autopsy | 24b. We | ere autopsy findings available or to completion of cause of | | |
| œ | The lav | E O | | | | | performe | #? de | ath? Yes 2 No | | |
| ita | | Be | 25. Was case referred to medical examiner? | | | | (Check only one) | • | | | |
| Division of Vital | Physicien: The this certificete har al director, page | P | 1 Yes 2 No Hospital: 1 Inpatient 2 ER/C | _ | | 4 Nulsing No | me 5 Residence 28d. Describe how | | | | |
| 'n | fing F After funer | ino | 1 Matural 5 ☐ Pending (Month, Day Year) | . Time of Injury | Work? | es 2 No | 200. Describe now | injury occurred | J | | |
| isic | Attending r death. ector: After y the fune | ficat | 3 Suicide 6 Could not be 28e. Place of Injury - At home. | farm, str | | | 28f. Location (Stree | t and Number | or Rural Route Number, | | |
| S | after Dire d in b | Certification; | 4 Homicide determined building, etc. (Specify) | | | | City or Town, S | itate) | | | |
| | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer | | 29a. Certifier 12 Certifying Physician: To the best of my knowled (Check only Americal Examiner: On the basis of examination a | ge, deatl | occurred at the time | , date and place, | and due to the caus | e(s) and man | ner as stated. | | |
| | the H in 24 the F nplete | Medical | and manner stated. | | | | | | (Month, Day, Year) | | |
| | 1 v v v v v v v v v v v v v v v v v v v | 2 | 29b. Signature and little of deritifier | | 29c. License | number | 1 290. | L I | (Monal, Day, Year) | | |
| | +1 | | 20 Name and addition of social who completed to the of social times and | a) /Tuna | Print) | 179- | 1 | 11.7 | 1.07 | | |
| | V ' | | 30. Name and addre is of person who completed quuse of death item 23a | 30 | VICIN & | Ann D' | RZ Yu | Siden | 1 MO 1112 | | |
| | St | ate | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | FA | | 171/2 | | - WI | | | |
| | Regist | rar | KOA & O TOOD STATE | 3 | | | | | | | |

State of Maryland / Department of Health and Mental Hygien@ [] [] § Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nav Month Physician TONY JUARASCIO 24, 2006 NOVEMBER /Medical 12:05 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHABILITATION HARFORD FOREST HILL

nder 1 Year If Under 24 Hrs.
ths Days Hours Min. If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Dav. Year) 1**□**M 2□ F 215-22-3874 Months 79 Director June 10, 1927 WVA Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at Completed by Funeral Director Harford 1 ☐ Yes 2 ☑ No Forest Hill Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 329 Bynum Ridge Road 21050 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

y yes 2 □ No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be itled within 72 hours after c Department of Health and Mental Hygiene. International important: if item 27 is marked other then "natural", or iter may injury or other traumatic event, the Medical Examina. 9081. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) stee1 12 years Manufacturing Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Sam Juarascio Filomena Inquinta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tony Juarascio, Jr./son 226 Mary Jane Lane, Bel Air, Md. 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gdns. 11/27/06 Bel Air, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. ste 610 W. MacPhail Road, Bel Air, Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cernes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy φ Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 5 1□ Yes 2 No 2No 1 Tyes filled in by the funeral director, 25. Was case referred to medical examiner?
1 \(\text{Yes} \) Yes To Be 26. Place of Death (Check only one, Hospital: 1 | Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Naturat Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident 6 Could not be determined 3 Surcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Tise thing in resonant: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Darl 5 J 032255 November 24, 7000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 DR. DAVID DUNN - 615 W. MACPHAIL ROAD, SUITE 106 - BEL AIR, MD 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

| | | | For State Registrar | ricase | State of M | | d / Depa | | f Health | and Me | ntal Hyg | jiene leg. No. | 006 | 37534 | |
|----------------------------|--|------------------|---|---------------------|-----------------------|-------------------------|------------------------|-----------------------------------|----------------|----------------------|---|-------------------|---|--|--|
| | Dhuaisi | | 1. Decedent's Name (First, Middle, Last) | | | | | | | 2 | . Date of Dea Month | th Day | Year | 3. Time of Death | |
| | Physicia /Medic | | THOMA | S JOSEF | H JOHNS | ON | | | | | | 22- | 2:50A M | | |
| | Examin | | 4a. Facility Name (If r | | | | | | m, or Location | | | | 4c. County of Death | | |
| | | | MANOR CARE RUXTON | | | | | | IMORE | 04115 | | BALTIMORE | | | |
| | Funeral Director | | 5. Social Security Nur 341-20- | 4081 | 9x 7. Ag | 79 | last birthday) Yrs. | If Under 1 Ye Months Da | | Min. | Date of Birtl (Month, Day 5 / 1 1 / | 1927 | 9. Birth Cou PHI | place (State or Foreign intry) LADELPHIA | |
| | and w | | Usual Residence of D 10a. State | 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | | | 10d. Inside City Limits | |
| | Manyl f sho | ō | MD | BALTIMO | RE | ידיי | MONIU | νī | | | | | | 1 Yes 2 No | |
| | death with the Maryland ms 23a or 28a-f show [Trius] be trulling at | Funeral Director | 10e. Street and Numb | | | | | 10f. Zip Cod | de | | | 10g. Citizer | n of What Cou | intry? | |
| | with 3a or | ٥ | 12021 TRALEE RD. UNIT 203 | | | | | 21 | 093 | | USA | | | | |
| | ns 2: | era | 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 3 Nidowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates: | | | Ever in U | .S. 13. | Was Decedent f Yes, specify (| of Hispanic Or | igin? (Speci | fy Yes or No- | | 14. Race - American Indian, Black, White, etc. | | |
| (0 | r Iter | Ē | | | | No. | 1 | | | | can, etc.) | | | | |
| 8 | hours after tural', or ite al Examine | b | | | | 1 ☐ Yes 2 🕱 No Specify: | | | | : | | Sp | Specify: WHITE | | |
| 2-0 | in 72 hours after death with the Marylan "natural", or Items 23s or 28s-1 show wolcal Examiner must be nutified at | Completed | 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working | | | | | | | , | 16b. Kind of Business/Industry | | | | |
| 2 | within 72 ene. than "nat | pg. | Elementary/Second | | College (1-4or | 5+) | life. | DO NOT use re | etired) | | | CONT | OTT DE | | |
| 7 | e filed within al Hygiene. I other then " | Con | 12 | | 4 | | VICE | PRESI | | | | | SULTI | NG | |
| pu | be file tal Hy d oth | Be | 17. Father's Name (F | irst, Middle, Last) | | | | | 18. Moth | er's Name (| First, Middle, | Maiden Su | <i>m</i> ame) | | |
| <u>ya</u> | Men Men arke | 10 | THOMAS | | | | | | | | E DeB | 1000000 | | | |
| Maryland 21215-0036 | s 1 and 2 should be filed withing Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Mental County, the Mental Cou | | 19a. Informant's Nan | | | | | ng Address (Str | | | | | | | |
| | and ealth m 27 | | DAWN L. | | ON-WIFE | 005 5 | | TRAL | | . TIM | | | 2109 | | |
| ore | of H of H if itel | | 20a. Method of Dispo | | Removal from State | | emetery, crei | sition (Name o natory or other | place) | | | | tion - City or T | own, State | |
| <u>E</u> | Pag ment ant: ury c | | `4 □Donation 5 | Other (Specify | y) | EV | | JNERAL | | | | | | HILL, MD | |
| Baltimore, | permit. Pages 1 and 2 Department of Health a Important: if item 27 it any injury or other tra | | 21. Signature of Fureral Service Licensee 22. Name and Address of Facility PEACEFUL ALTERNATIVES FUNERAL AND CRE CENTER 2325 YORK RD. TIMONIUM, MD 21093 23a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or one and failure. List only one cause on each line. 25a. Name and Address of Facility PEACEFUL ALTERNATIVES FUNERAL AND CRE CENTER 2325 YORK RD. TIMONIUM, MD 21093 Approximate Interval Between Onset and Death Onset and Death | | | | | | | | | | | AND CREM | |
| | Physician /Medical | | 23a, Pert 1. Enter the | disease, or com | plications that cause | d the deat | th. Do not en | SNTER er the mode of | dying, such as | YORK - cardiac or | RD. Trespiratory an | TMON | TOM , MI | Approximate | |
| 9 | | | shock, or heart Immediate Cause (F disease or condition resulting in death) | IIIai | a. Due to (or as | start | cc t | rasta | te (| Carc | inon | ra | | Interval Between Onset and Death | |
| | Examiner | <u></u> | Sequentially list cond | ditions, | b. Due to (or as | as a consequence of): | | | | | | | | | |
| .8. | nted Insit | Examiner | Sequentially list condificant, leading to immocause. Enter Underlicause (Disease or in that initiated events | ying njury | Due to (or as | | | | | | | | | | |
| m. | be executed sicien and burial-transit | Еха | resulting in death) La | ast | Due to (or as | s a consec | quence of): | | | | | | | | |
| ,092 | te be exystite no section to buria | cai | | • | d | | | | | | | | | | |
| 89 | ificat g phy as thi | | | | | | | | | | | | | | |
| Вох | death certificate t attending physic of for use as the t | Z | IF FEMALE: 23b. Was decedent i | pregnant | 23c. If yes, outcome | | | Ectopic pregn | | | | 230 | d. Date of deliv | very | |
| | The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the | Physician/Medi | in the past 12 m | | 4 Pregnant a | | | Other (specif) | | | | | Month | Day Year | |
| P.0 | t the by th | hys | 9 🗆 Unknown | | 9□ Unknown | | | | | | T | | | | |
| Ψ. | v requires that the de been signed by the should be detached | by P | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23e. Did to | Did tobacco use contribute to the cause of death? | | | | |
| rg. | quire an siç ald b | | 1 T | | | | | | | | es 2 No 3 Probably 4 Unknown | | | | |
| o O | aw re | Completed | | | | | | | | | 24a. Was | | 24b. Were aut | opsy findings available | |
| Re | The lav | E | | | | | - | | | | perfor | med? | death? | | |
| tal | | a) | 25. Was case referre | ed to medical | | | | | 26. Plac | e of Death / | Check only o | * | 1 1 103 | 24110 | |
| > | /sicia s cer direct | 0 | examiner? 1 ☐ Yes 2 ☑ | | Hospital: | ient 2 | ER/Outpatie | nt 3 DOA | Other | | | | Other (Speci | ifv) | |
| Division of Vital Records, | g Phy erthi | | | | | | | | | | | | | | |
| Ö | nding tth. :: Aft | atio | 1 Month, Day Year) Injury Work? 2 Accident investigation (Month, Day Year) Injury Work? 1 Yes 2 No | | | | | | |]No | | | | | |
| <u>S</u> . | Atte | ific | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not b | 286. Place of II | | | eet, factory, of | fice | 28 | If. Location (S City or Tow | | vumber or Rui | ral Route Number, | |
| Ö | al or s afte of Dir | Certification: | - I Tourida | | building, e | no. (Speci | 7/ | | | | 5, G. 10h | , 5(4(0) | | | |
| | To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, | | | | nysician: To the bes | | | | | | | | | | |
| | the H in 24 he Fi plete | Medical | one) | | and manner s | | | | | 50001180 | | | | | |
| | To t To t | Σ | 29b. Signature and t | itle of certifier | 1 | 120 | 0. | | cense number | | | | signed (Month | | |
| | | | 1 lo | 2/f | och | 00 | w. | | 0054 | | | | 22- | | |
| | 5 | | 30. Name and addre | ss of person who | completed cause of | death (Ite | m 23a) (Type, | Print) | | - | | | 110 | 21-03 | |
| |) | | Cyrus | Asadi | ,20 E. | lun | roniur | n rd. | #209 | lin | roniu | m// | VII) | 21075 | |
| 4 | Sta | ate | 31. Date filed (Month | n, Day, Year) | 32. Angis | trar's Sign | ature | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Ub Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5 2406 lovember 2 /Medical Pacility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Vorthwest Hospita lotown Kanda saltimore 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Pay, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X Yrs Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits other than "naturel", or iteme 23s or 28s-f ehow vent, the Medical Examinar must be notified at Baltimore MD 1 es 2 No by Funeral Director 10g. Citizen of Whal Country? 10e. Street and Number 10f. Zip Code 2000 Avenue lowana 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 You If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use regired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) omesti omes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willis and Mental aura 19a. Informant's Name/Belationship (Type, P in 19b. Mailing Andress (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4710 Avatar Heelth a Owings Mills .. Kichardson 20b Place of Disposition (Name of Date 20a. Method of Disposition Department of H Important: If Ite eny injury or ot once. cometery crematory or 1 ABurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State 28-2006 Baltimore 21. Signature of Funeral Service Kanda 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death SEPSIS **Physician** /Medical Due to (or as a consequence of): Health care allogiated Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy Month Day 4 Pregnant at time of death signed by the a 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? luno 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an aneuryms certificete 1 ☐ Yes 2 LNa To the Hospital or Attending Physicien: 25. Was case referred / medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient Medical Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this After this funeral of 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Yeak)

Ramagwames

28

2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rangaragan

32. Registrar's Signature

054288

Vorthwest Hospital Center

29d. Date signed (Month, Dey, Year) November 25 2evo6

| | | | For State Registrar | State of M | aryland | - | rtment of l | | nd M | - | giene Reg. No | 2006 | 37 | 536 |
|---------------------|--|------------------|--|-----------------------------------|---|--|---|--------------------------------|--|----------------------------------|-----------------------------------|------------------------|---------------------------------------|-----------------|
| E | Physici /Medic | | 1. Decedent's Name (First, Middle, M o S & S | | YNE | R . | JR | | | 2. Date of De Month | ath Day | Year 200 | | ol Death |
| } | Examin | | 4a. Facility Name (If not institution, | give street and number) | | | 4b. City, Town, o | or Location of | Death | | 4c. | County of De | ath | |
| | | | Howard Co. Gener | | | | Columbi | | | | F | Ioward | Co. | |
| | Funeral Director | | 220-40-3172 | 3. Sex 7. Ag | 9e (In yrs. Ia 67 | st birthday) Yrs. | If Under 1 Year Months Days | If Under 2 | Min. | 8. Date of Bir (Month, Da 10/29/ | y, Year) | (| irthplace (Stai Country) th Car | - |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, | Town or Loc | ation | | | | | | 10d. Inside | City Limits |
| | Mary f •hc | ত | MD Howar | đ | Jes | sup | | | | | | | | es 2 No |
| | r 28a | Funeral Director | 10e. Street and Number | | | - 1 | 10f. Zip Code | | | | 10g. Citi | zen of What (| Country? | <u>-</u> |
| | h with | aiD | 8029 Lincoln Dri | ve | | | 207 | 794 | | | US | SA | | |
| | deal | ner | 11. Marital Status | 12. Was Decedent Armed Forces? | | S. 13. V | Vas Decedent of I Yes, specify Cub | | in? (Spe | city Yes or No | | | nencan Indian | |
| 36 | or it | J. | 1 Never Married 2 Marrie | | | 1 | ☐ Yes XX No | | | noan, oto., | | SpecifyB1a | | |
| Ö | hour: | ed by | 3 Widowed 4 Divorced 15. Decedent's | | 16a. Decedent's Usual Occupation | | | | | | 16b. Kind of Business/Industry | | | |
| 21215-0036 | permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "natural", or Itams 23a or 28a-f show early fijury or other traumatic event, the Medical Examinar must be notified at once. | Completed | (Specify only highest | grade completed) | | (Give I | ent's Usual Occup kind of work done OO NOT use retire | during most of | of workit | ng | 16b. Kii | nd of Busines | s/Industry | |
| 212 | r the | шо | Elementary/Secondary (0-12) | College (1-4or | 5+) | Ware | housemar | · } | | | Fast | Coast | Tre C | ream Co |
| ק | othe | Bec | 17. Father's Name (First, Middle, La | ast) | | ware | 110000ciikai | 7 | 's Name | (First, Middle, | | | . 100 0 | ream co |
| Baltimore, Maryland | uld by Menta Menta Irkad Itlc e | To E | Moses Joyner | , Sr. | | | | Addi | ie L | ee Will | liams | ; | | |
| ar | and l | | 19a. Informant's Name/Relationshi | p (Type, Print) | | 19b. Mailin | g Address (Street | and Number | or Aura | / Route Number | er, City or | Town, State, | Zip Code) | |
| ≥ . | end and m 27 | | <u>Eveline Joyner/S</u> | ister | | 8029 | Lincoln | Dr., J | Jessi | up, MD | 2079 | 4 | | |
| ore | If Ite | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 | B □Removal from State | 20b. Pla | ace of Dispos metery, crem | sition (Name of natory or other pla | | | ate | 20c. Lo | cation - City of | or Town, State | |
| Ë | tant: | | 4 □ Donation 5 □ Other (Spe | | MD 1 | Nation | | | 1/29, | /06 | Lau | rel | | |
| Bai | Deparent Important Inches | | 21. Signature of Funeral Service Li | cenade > | 21012 | | Name and Addre | | | eral Ho | me (| MMP_ | Inc. | |
| | | | 23a. Part1. Enter the disease, or c | excelled 1 | the death | Po not onto | rv L. Ka 50 Washi | ngton | Blv | d., Elk | ridg | re, MÓ | 21075 Approxim | |
| E | Physician /Medical Examiner putal-itansit | | shock, or heart failure. List of tmmediate Cause (Final disease or condition resulting in death) | nty one cause on each li | ne. | NYE | LOFA | | a diac o | Toophatory a | 11031, | | Interval 8 Onset ar | Between |
| | | | Due to (or as a consequence of): | | | | | | | | | | | |
| | | ē | Sequentially list conditions, it any, leading to immediate Due to (or as a consequence of): | | | | | | | | | | - | |
| 13. | | Examine | cause Enter Undertying Cause (Undeaus or injury that initiated events c | | | | | | | | | | | |
| o O | e exe ien al urial-t | EX | resulting in death) Last | Due to (or as | a conseque | ence of): | | | | | | | | |
| 8760, | ate be ex hysicien the buria | dicai | | d | | | | | | | | | | |
| Вох 6 | Attending Physician: The law requires thet the deeth certificate be executed to death. crost. After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit. | Physician/Medi | IF FEMALE: | 23c. If yes, outcome | of pregnan | io. | | | prille and all the same | | | | | |
| Bo | eeth e | clan | 23b. Was decedent pregnant in the past 12 months? | 1 ☐ Live birth 4 ☐ Pregnant a | 2 Fetal | death 3 🗌 | Ectopic pregnancy Other (specify) | у | | | 2 | 3d. Date of d Month | elivery Day | Year |
| o. O | the d yy the ached | lysi | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□ Unknown | | | other (speedy) _ | | | | | | | |
| | w requires thet the d been signed by the should be detached | by PI | Part II. Other significant condition | s contributing to death b | out not resul | ting in the un | derlying cause giv | ven in Part I. | | 23e. Did to | obacco u | se contribute | to the cause o | of death? |
| Records, | equire en sig ould b | | DM Z, 1 | ITN A | he | mic | · Lah | kope | 21.5 | 10 | Yes 2[|]No 3∏ | robably | ⊟Unknown |
| ပ္ပ | e law re has be je 2 sho | Completed | Thrombo | uy be ben | è / | norb | J OE | الماعصر | | 24a. Was | | 24b. Were a | autopsy finding | gs available |
| œ | The ete h | ĕ | | • | | | | | | autor perfo | rmed? | death? | | , cause of |
| Vital | cian: ertific actor. | Be (| 25. Was case referred to medical examiner? | | | | | | of Death | Check only o | | | | |
| <u>}</u> | hysi this c | 은 | 1 Yes 2⊒No | Hospital: | | | | | Nursing Home 5 ☐ Resider | | | nce 6 ☐Other (Specify) | | |
| ב | ling F | 0 | 27. Manner ol Death → Naturat 5 ☐ Pending | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury | | | Work? | | | 28d. Describe how injury occurred | | | |
| <u>is</u> | death death stor: | icat | 2 Accident investigat 3 Suicide 6 Could no | | M 1 | 101 (applies // | BL Location (Street and Number of Burel Boute Number | | | | | | | |
| Division of | after Direct In by | Certification: | 4 Homicide determined 28e. Place of Injury - At home, Iarm, street, factory, office building, etc. (Specify) | | | | | | lory, office 281. Location (Street and Number or Rural F City or Town, State) | | | | | um <i>ber</i> , |
|) | To the Hospital or Attending Physician: The inwithin 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page | Medical C | 29a. Certifier 1 Certifying (Check only one) 2 Medical E | Physician: To the best | f examination | rledge, death on and/or inv | occurred at the till estigation, in my o | me, date and opinion, death | place, a | and due to the | cause(s) date and | and manner a | as stated. ue to the caus | e(s) |
| | To the within 2 To the Comple | Me | 29b. Signature and title of certifier | and manner st | | | 29c. Licens | | | | 29d. Date | signed (Mo/ | nth, Day, Year | ·) |
| | -> - ō | | PriL | com 8 | | | \mathcal{D} | 586 | 9 5 | 3 | | | 4200 | |
| | 5 | | 30. Name and address of person w | ho completed cause of c | feath (Item : | 23a) (Type, i | Print) PR | ITA | m | 5521 | ~1 | MA | * | |
| | .7 | | 910, Ch | one /a | 0 | SINIL | - 21/ | Lew | معه | MD | 2 | 070 | 8 | |
| | Sta | _ | 31. Date liled (Month, Day, Year) | 32. Registr | ar's Signatu | пе | 29 | | | | | | | |
| | Registr | ar | NOV 2 8 20 | UD FRANKLE | 80 6 | The same of the sa | | | | | | | | |

| | | | For State | State of Maryland / | | | | ental Hyg | iene | 006 | 37537 |
|----------|--|----------------|--|---|---|-------------------------------------|--------------------------------|-------------------------------------|----------------|-------------------------------------|-------------------------------------|
| | | | Registrar | | Certificat | e of Dea | | | eg. No. | | 0,00, |
| | Physici | an | Decedent's Name (First, Middle, Last, | | | | | 2. Date of Dea Month | th Day | Year | 3. Time of Death |
| 3 | /Medic | | 771 | | nozi | | | - 11 | le | 1 2006 | 11:16 A M |
| • | Examin | er | 4a. Facility Name (If not institution, give | Dedical Certer | 4b. City, | Town, or Locati | _ | | 4c. Co | N A | |
| | Funeral | _ | 5. Social Security Number 6. Sec | | | 1 Year If Un | ider 24 Hrs. | 8. Date of Birth | 1 , | | lace (State or Foreign try) |
| | Director | | 219-52-7745 | M 2□F 57 | Yrs. Months | Days Hou | ırs Min. | (Month, Day | 1949 | Coun | MD |
| | 2 | | Usual Residence of Decedent | | | | | | | | |
| | death with the Maryland ms 23a or 28a-f ehow rinust be notified at | h. | 10a. State 10b. County | 10c. City, Tov | m or Location | | | | | 10 | 0d. Inside City Limits |
| | Ba-f | Director | MD NA | 1201+ | more | | | | | | 1 AYes 2 No |
| | or 2 | | 10e. Street and Number | | 10f. Zip | Code | | 1 | 0g. Citizer | n of What Coun | try? |
| | 23a | B | 2115 PRESIDURY | 5+ | 213 | 717 | | (| JSJ | Δ | |
| | ep .e | Funeral | 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Deced | tent of Hispanic offy Cuban, Mex | Origin? (Speckican, Puerto F | city Yes or No- lican, etc.) | 14. | Race - America Black, White, e | |
| 9 | orl | by Fi | t Never Married 2 Married | 1 X Yes 2 □ No If Yes, Give | 1 ☐ Yes | 2 No Spe | cify: | | Sp | pecify: | V |
| 003 | hours after turel', or ite | | 3 Widowed 4 Divorced | Year or Dates: | Deceded to | | | | 101 165-1 | DIG | CK |
| 2 | within 72 ene. then nat | Completed | 15. Decedent's Edu (Specify only highest grad | a completed) | a. Decedent's Usua (Give kind of wo life. DO NOT us | rk done during i | most of workin | g | 16b. Kind | of Business/Ind | lustry |
| 7 | the the | E | Elementary/Secondary (0-12) | College (1-4or 5+) | 12000 | Mont | 2/22 | | | | |
| 0 | Hygi Hygi ent, | | 17. Father's Name (First, Middle, Last) | Z/ZCAS | ngger | 18. M | lother's Name | (First, Middle, | Maiden Su | тате) | |
| <u>a</u> | ld be ental ked o | To Be | Hamad 10:11:00 | n Jackson | | Do | loses | 1 | 1200 | 212 | |
| 2 | 2 should and Men le marke aumatic | - | 19a. Informant's Name/Relationship (Ty | | b. Mailing Address | (Street and Nu | | Route Number | City or To | own, State, Zip | Code) |
| <u> </u> | and 2 ealth a n 27 le | | Taking Jarken | (drughter) 21 | 115 Presh | ELPIN SH | Roll | more. | M | 21217 | 7 |
| <u>6</u> | -IPE | | 20a. Method of Disposition | 20b. Place of | of Disposition (Nar | ne of O | 4 6 2 2 | | 20c. Local | tion - City or To | wn, State |
| <u> </u> | | | 1 ☐ Burial 2 🗷 Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify) | ternoval from State / | ery, crematory or o | , , | In But | 2001 | 110 | more, | 10 |
| aitimo | | | 21. Signature of Funeral Service Licens | ee | 22. Name an | d Address of Fa | | | | more, r | 40 |
| ñ | permit. Depertrimports ony injure. | | Naudan C | "Groone | 5151 P | d Address of Fa | | reeal Svi | | e, MD | |
| п | | | 23a. Part1. Enter the disease, or compl shock, or heart failure. List only or | ications that caused the death. Do | | - | | | | 2010 | Approximate |
| | Physician | | Immediate Cause (Final | 22 | | | | | | | Interval Between Onset and Death |
| je. | Physician /Medical | | disease or condition resulting in death) | Due to (or as a consequence | | | | | | | |
| | Examiner | | | bue to (or as a consequence | oi). | | | | | | |
| | | ler | Sequentially list conditions, if any leading to immediate | Due to for as a consa uence | of): | | | | | | |
| 8. | uted d ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | |
| | exec n an iai-tr | Exa | resulting in death) Last | Due to (or as a consequence | of): | | | | | | |
| Q/Q | certificate be executed uding physicien and use as the burial-transit | dlcal | | j | | | | | | | |
| ĝ | tifical ig phy as th | led | | | | | | | | | |
| X Q | h cer endin | Iclan/Me | IF FEMALE: 23b. Was decedent pregnant | 3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death | h 3 DEstania as | | | | 23d | I. Date of delive | ry |
| מ | w requires that the death certifit been signed by the attending f should be detached for use as | SICIE | in the past 12 months? 1 \(\sumset \text{Yes} 2 \sumset \text{No} \) | 4 Pregnant at time of death | h 3 ⊟Ectopic pr 5 □ Other (sp | | | | | Month | Day Year |
| , 5 | by the | hys | 9 Unknown | 9LJ Unknown | | | | 1 | | | |
| Ś | requires that the | by Physi | Part II. Other significant conditions cor | stributing to death but not resulting | in the underlying c | ause given in Pa | art I. | 23e. Did to | bacco use | contribute to the | e cause of death? |
| ב | equir en sl ould l | ted | | | | | | 1 🗆 Y | 9S 2 | No 3 ☐ Proba | ably 4 Unknown |
| ecords | 2 8 8 | Completed | | | | | | 24a. Was a | n 2 | 4b. Were autop | sy findings available |
| r | o - E iii | E O | | | | | | perfori | ned? 2 □ No | death? | 2.2 No |
| VII | ician: Th certificate rector, pag | Bec | 25. Was case referred to medical | | | 26. P | lace of Death | (Check only on | | | |
| <u> </u> | nysic nis ce | 2 | examiner? | lospital: 1 x npatient 2 ☐ ER/O | utpatient 3 DC | Other: 4 | Nursing Hom | e 5 🗆 Reside | ence 6 | Other (Specify |) |
| | ng Pt Iter tr neral | | 27. Manner of Death 1 Natural 5 ☐ Pending | | Time of 2 | 8c. Injury at Work? | 2 | d. Describe he | w injury o | ccurred | |
| ŏ | andii path. or: A he fu | atle | 2 ☐ Accident investigation | | М | 1 ☐ Yes 2 | 2 □No | | | | |
| UNISION | r Att | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At home, for building, etc. (Specify) | arm, street, factory | , office | 2 | Bf. Location (SI City or Town | reet and N | lumber or Rural | Route Number, |
| 2 | irs ef | Ce | | | | | | | | | |
| | To the Hospital or Attanding Physician: within 24 hours effer death. To the Funarel Director: Affer this certific, completely filled in by the funeral director, | edical | 29a. Certifier Check only one) Check only 2 Medical Exami | sician. To the best of my knowledg ner: On the basis of examination ar and manner stated. | ja daath seniured nd/or investigation. | at the time, date in my opinion, | e and place a death occurre | nd due to the c d at the time, d | ate and pla | d mainter as etc ace, and due to | ited. the cause(s) |
| | o the o the omple | Me | 29b. Signature and title of certifier | and manifel stated. | 290 | . License numb | Der Der | | 9d. Date s | igned (Month, L | Day, Year) |
| | ⊬≱≓ö | | 11 1 | CA MON | | P 197 | _ | | 1 | 19/20 | |
| | . 1 | | 30 Name and address of access in | moleted course of desit (them on) | | 1 1 1 7 | · \ | | 111 | 17120 | C/6 |
| | 4 | | 30. Name and address of person who co | | | zere S | Street ! | Ralhimo | ~ e . | min a | 1201 |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32 Registrar's Signature | Amerika 2 | - 310 | -11-21 | J. 1731716 |) | VII) d | 100 |
| | Registr | | NOV 2 8 20 | 06 plesses de | 1 | | | | | | |

| | | | 1 - For State Registrar | State | of Marylar | _ | artment of I | | | - | giene Reg. No. | 006 | 3753 | 8 |
|---------|---|------------------|--|-------------------|---|-----------------------------------|---|-----------------------------|-----------------------------|---------------------------------|--------------------------|---|---|----------------|
| | Physici | | Decedent's Name (First, Middle, La ARLINE M. | st) | | | JOHANSE | N | | 2. Date of De Month NOV • | Day | Year 2006 | 3. Time of De 0806 | ath M |
| | /Medio Examin | | 4a. Facility Name (If not institution, giv | | mber) | | 4b. City, Town, | or Location | | 10 4 4 | 4c. (| County of Death | 1 | |
| | Funeral Director | | 5. Social Security Number 6. S 216-20-3341 | | 7. Age (In yrs. | . last birthday) Yrs. | OCEAN If Under 1 Year Months Days | If Under | 24 Hrs. Min. | 8. Date of Bir (Month, Da | th ly, Year) | 9. Birth | nplace (State or Fountry) | oreign |
| | | | Usual Residence of Decedent 10a. State 10b. County | | | ity, Town or Lo | cation | | | SEPT. | 11,1 | 927 MAR | YLAND 10d. Inside City L | imits |
| | the Mary 28a-f sh notified | Funeral Director | MARYLAND WORCESTI | ER | ОС | EAN CIT | 10f. Zip Code | | | | 10a, Citiz | zen of What Co | 1 ☐ Yes 2 | X No |
| | th with 23a or | al Di | 607 141ST STREET | | | | 21842 | | | | | ED STAT | • | |
| 200 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be multified at once. | by Funer | 11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced | Armed F | 2 (XNo ive | 1 | Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 🛣 No | | | cify Yes or No Rican, etc.) | | 4. Race - Amer Black, White Specify: WH | | |
| D-612 | athin 72 hou ne. nan "natura Manical E | Completed | 15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) | de completed, | 1-4or 5+) | (Give | tent's Usual Occu kind of work done DO NOT use retire | durina mos | st of workin | g | | nd of Business/I | | |
| 2 | e filed wall Hygier other the | Be Cor | 17. Father's Name (First, Middle, Last |) | | HOME | MAKER | 18. Mothe | er's Name | (First, Middle | | N HOME Sumame) | · · · · | _ |
| ya | hould b d Menta narked natic e | ToE | CARL WEILAND, SR. 19a. Informant's Name/Relationship (| | | 10h Mailie | ng Address (Street | | LINE | | or Cityon | Town State 7 | in Codol | |
| , Ma | and 2 seatth an 27 ta i | | STEVEN JOHANSEN, | | | 607 1 | 41ST STR | | | | | | | |
| | Pages 1 nent of He int: If iten iry or oth | | 20a. Method of Disposition 1 ☑ Gurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia | | State | cemetery, crer | sition (Name of natory or other pla EN MEM.] | | NOVEMI 200 | BER 30 | | ation - City or BURNIE | Town, State | ND |
| Dall | permit. Departn Imports any injt | | 21. Signature of Funeral Service Lice | nsee | 1 | K1 42 | RKLEY-RU 1 CRAIN | DDICK HWY. | FUNE | RAL HO GLEN | ME, I | P.A. IE, MD | 21061 | |
| | Physician /Medical | | 23a. Part 1. Enter the disease, or com shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death) | a | -71 | TES | er the mode of dyi | | cardiac or | respiratory a | rrest, | 5. | Approximate Interval Betwee Onset and Dea | n th |
| | cate be executed physician and ithe burial-transit | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | (or as a conse | | | | | | | | | |
| O. DO. | To the Hospital or Attending Physician: The law requires that the death certific within 24 hours elder death: within 24 hours elder death: To the Funeral Director: After this certificate has been signed by the attending placompletely filled in by the funeral director, page 2 should be detached for use as t | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 Live | itcome of pregn birth 2 Fet nant at time of a | al death 3 ☐ | Ectopic pregnanc | у | | | 2 | 3d. Date of deli | very Day Yea | r |
| L (SD) | quires that in signed by uld be deta | þ | Part II. Other significant conditions of ASCVD | contributing to d | leath but not re | sulting in the u | nderlying cause gr | ven in Part I | | | obacco us Yes 2 | | the cause of deat | |
| i necol | aician: The law re s certificete has bee lirector, page 2 sho | Completed | | | | | | | | 24a. Was autor perfo | | prior to o death? | opsy findings ava ompletion of caus | ilable e of |
| VILC | aician s certifi lirector, | To Be | 25. Was case referred to medical examiner? 1 ★ Yes 2 □ No | Hospital: | Inpatient 2 |] ER/Outpatien | 3 DOA 0t | 205 | | (Check only o | | Other (Spec | (6.) | |
| | anding Phyaician: The ath. or: After this certificete ha funeral director, page | | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date (Mor | | 28b. Time of Injury | 28c. Inju Wo | ry at | 21 | 8d. Describe | | | | |
| | To the Hospital or Attentwithin 24 hours efter death To the Funeral Director: completely filled in by the | Certification; | 3 Suicide 6 Could not be determined | 286. Plac | e of Injury - At h ling, etc. (Spec | nome, farm, str ify) | eet, factory, office | | 2 | 8f. Location (City or Tox | Street and wn, State) | Number or Ru | ral Route Number | |
| | n 24 hour n 24 hour ne Funer bletely fill | edical | 29a. Certifier (Check only one) | niner: On the I | e best of my kn pasis of examin nner stated. | owledge, death ation and/or in | occurred at the ti restigation, in my | me, date ar opinion, dea | nd place, as oth occurre | nd due to the d at the time, | cause(s) a date and (| and manner as place, and due | stated. to the cause(s) | |
| | To the To the Comp | Σ | 29b. Signature and title of certifier | Action | | 2 | 29c. Licen: | | | | | signed (Month | - | |
| | V | | 30. Name and address of person who | completed cau | se of death (Ite | m 23a) (Type, | Print) | 062 | 4-1 | | <i>- 11-</i> | 11 | | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 2 8 | 2006 | Registrar's Sign | ature | Print) | 203 L | 715(s) | J7, V | i NEUR | MILL | WD, 2186 | 3 |

DHMH 17 Rev 1/2001

-U0904

Please Type or Print in Black Indelible Ink

| Antoine Rashard J | | nson State of Maryland / Department of Health and Mei - For State Certificate of Death | ntal Hygi | | 200 | 5 3753 |
|---|---------------|--|-----------------|--------------------------------|-------------------------------------|-------------------------------------|
| Physician | _ | Registrar 1. Decedent's Name (First, Middle, Last) | | Date of Death | No 200 | 3. Time of Death |
| Medical Examine | | Antoine Rashard Johnson | N | Month lovember 2 | | 1435 hrs |
| y k | | 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location | n of Death | | 4c County of Death Baltimore Cou | |
| | | | der 24Hrs. 8 | Date of Birth | (MM/DD/YYYY) 9 Bir | |
| Funeral Director | | Months Days Hou | ırs Mın. | 04/21/ | Foreig | |
| | | Q30-94-4700 1 X M 2 F 38 Yrs Usual Residence of Decedent | | JUIANI | 1910 | |
| , any | Ī | 10a. State 10b. County 10c. City, Town or Location | | | | 10d Inside City Limits 1 X Yes 2 No |
| fand fahov | ទ្ធ | MD N/A Baltimore 10e Street and Number 10f Zip Code | | 100 | Citizen of What Cou | |
| e Mary or 28a | Director | | | | | nu y |
| vith the | | UIOI Loch Raven RVd Apt 314 319 39 11, Marital Status 12. Was Decedent Ever in U.S. 13 Was Decedent of Hispanic O | | y Yes or No- | | ican Indian, 8 lack, |
| death v | Funeral | 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexical Yes 2 No | an, Puerto Rica | an, etc.) | White, etc. | |
| after (| ă a | 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specification of Dates: | | | Specify Blo | |
| hours "natu | | Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Given during most of working life. DO NO. | | done | 16b. Kind of 8usinessi | industry |
| hin 72 hin 72 le than' | ompleted | 12th Grade Resource Specia | list | | Health C | are |
| 215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica | ၁၂ | 17. Father's Name (First, Middle, Last) 18.Moth | er's Name (Fir | st, Middle, Ma | aiden Surname) | |
| 2121 nuld be fi Mental marked | | Konald Johnson 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and No. | cila B | arden | ner City or Town State | Zip Code) |
| Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other transmitter very. | <u> </u> | Lisa M. Johnson (wife) (old Loch Bayen B' | lvd Ad | 316. P | Golfmore N | 10 21239 |
| e, N l and l Health item | f | 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, | Da | | 20c. Location - City or | Town, State |
| Baltimore, bernit Pages I at Department del Important: If ite injury or other tr | ļ | A Possing 5 Other Specific David Ridac | 11/30/ | 2006 | Pikesville | MD |
| altii | Ī | 21. Signature of Funeral Service Licensee Vauchy C. Green 5151 Patto Vict | lity Fu | neral s | SVC | |
| | _ | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as | Pike | Baltima spiratory arres | st shock or heart | Approximate Interval |
| Physician /Medical | | failure List only one cause on each line | | -, , | , | 8etween Onset and Death |
| Examiner | | Immediate Cause (Final disease or condition resulting in death) a Cardiac arrhythmia Due to (or as a consequence of): | | | | |
| 1 | | Sequentially list conditions, if any leading to immediate b Arrhythmogenic right ventricular dysplant of the conditions | asia/ ca | rdiamyop | oathy | |
| | Examiner | If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated | | | | |
| ed sit | Exar | events resulting in death) Last Due to (or as a consequence of). | | | | |
| O, e be executed ysician and burial - transit | edical | d. X UNPENDED | OC (IIII) | | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death for this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transi | | IF FEMALE: 23c. If yes, outcome of pregnancy | 06 11 | | 23d Date of deliver | у |
| tox 6876 leath certificate attending phy for use as the learn | sician/M | past 12 months? | pic pregnancy | | Month | Day Year |
| Box 6876 e death certificat the attending phy ed for use as the | iysic | 1 Yes 2 No 9 Unknown 9 Unknown | | | | |
| O. Far the rat the etachee | y Phy | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in | Part I. | | pacco use contribute to | the cause of death? |
| ds, P.C | ed by | | | 1 Yes | | utopsy findings available |
| tal Records rian: The law requi certificate has been ector, page 2 should | Completed | | | autops perforn | y prior to | completion of cause of |
| Rec The l ficate b | S | 25. Was case referred to medical 26.Place of Dea | th (Charle and | 1 Y Yes 2 | | es 2 No |
| ital Fisions sician: | Be | examiner? Hospital: Inpatient 2 FR/Outpatient 3 DOA Other, | Nursing H | | Residence 6 Othe | er: |
| Division of Vital Records, tal or Attending Physician: The law requiring after death and Director: After this certificate has been so the fineral director, page 2 should led in by the funeral director, page 2 should be a so that this continues of the funeral director. | ٤١ | 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Wo | ork? 28 | d Describe ho | ow injury occurred | |
| ion tendir eath tor: A | atio | 1 X Natural 5 Pending 1 Yes 2 Accident Investigation | | | | |
| IVISION ALL after dain by | ertification: | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, | , etc. 28 | f. Location (St or Town, St | | ural Route Number, City |
| Divis Hospital or A 24 hours after Funeral Dire | ပ | 4 Homicide 29a. Certifier 4 Device - Review - R | place and du | e to the cause | e(s) and manner as sta | rted |
| Division To the Hospital or Attent within 24 hours after death To the Fineral Director: completely filled in by the | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated | occurred at th | e time, date a | and place, and due to t | he cause(s) |
| 7. wi | Me | 29b. Signature and title of certifier 29c. License numb | er | | 29d. Date signed (Mo | |
| | | Calulia C. C.M.E. | | | November 25, 2 | 6 |
| | | Name and address of person who completed cause of death (Item 23a) Zabjullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore | . MD 2120 | 1 | | |
| Sta | ata | | , = 1,20 | | | |
| Registr | | 31. Date filed (Month NOVe2) 8 2006 32 Restrar's Signature | | | | |

| | | | for State Registrer | State of Ma | | - | | t of H | ealth a | and M | - | /gieŋ | ខ្ញុំ |) 6 | 37540 |
|----------------------------|--|------------------|---|---|-----------------------------------|------------------------------|---|------------------------|------------------------------|---------------------------|----------------------------------|---------------------|-----------------------|--------------------------|---------------------------------|
| | | | Hegistrer Decedent's Name (First, Middle, Las | t) | | 007 | incate | 01 1 | Jean | | 2. Date of D | Reg. N | e. · | | 3. Time of Death |
| П | Physici | | Sarah Margaret | | | | | | | | Month Novemb | D | ay 23 | Year 2006 | 10:27 a ^M |
| | /Medic Examin | | 4a. Facility Name (If not institution, give | | | | 4b. City, | Town, or | Location of | | 110 7 CITIO | | - | y of Death | |
| Н | _xaiiiii | | 3582 Day Road | | | | Dar | ling | ton | | | I | Harf | ord | |
| | Funeral | | Social Security Number 6. Security Number | | (In yrs. las | st birthday) | If Under Months | | If Under Hours | 24 Hrs. Min, | 8. Date of Bi (Month, D | irth | r) | 9. Birth | place (State or Foreign |
| | Director | | 237-60-7347 | □M 280F | 75 | Yrs. | Working | Duys | 110013 | | | 5, | Ĺ931 | Sout | h'Carolina |
| | and | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, | Town or Lo | cation | | | | | | | | 10d. Inside City Limits |
| | Maryl 4 sho | ō | North Carolina Scotland | | Louise | b | | | | | | | | | 1 ☐ Yes 2 No |
| | 28a | Director | 10e. Street and Number | | Laur. | inburg | 10f. Zip | Code | | | | 10g. C | itizen of | What Cou | ntry? |
| | filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or Items 23a or 28a-f show sht, the Medical Exam mar nust be Indiffied at | al D | 1117 S. Pine Str | eet | | | 28 | 352- | 4742 | | | USZ | 4 | | |
| | deat | Funeral | 11. Marital Status | 12. Was Decedent E Armed Forces? | ver in U.S. | . 13. \ | | | | igin? (Spe | cify Yes or N Rican, etc.) | <u> </u> | 14. Ra | | can Indian, |
| 9 | or Ite | Fu | 1 Never Married 2 Married | 1 ☐ Yes 2 ☑N If Yes, Give | 0 | | l ☐ Yes | | Specify: | | ritodii, otc.) | | Speci | ick, White, | etc. |
| 21215-0036 | ural', | d by | 3 Widowed 4 □ Divorced | Year or Dates: | | | | | | | | 1 | | <u>Nati</u> | ve America |
| 5 | "nat | Completed | 15. Decedent's Ed (Specify only highest gra | | | 16a. Deced (Give | lent's Usua kind of wol DO NOT us | il Occupa rk done d | ation during mos | t of worki | ng | 16b. | Kind of E | Business/Ir | ndustry |
| 12 | within ene. than | d L | Elementary/Secondary (0-12) | College (1-4or 5- | +) | Nurse | | | | | | Ц | \~1+1 | n Car | 0 |
| 0 | Hygi other ent, | Be C | 17. Father's Name (First, Middle, Last) | | | NULS | יכת ככ | STSC | | er's Name | (First, Middle | | | | e |
| <u>a</u> | lid be lental ked o ic eve | To B | Clifton (unk) | Lowery | | | | | Leol | .a (| unk) | Reve | els | | |
| Maryland | 2 shou and N is mai | _ | 19a. Informant's Name/Relationship (7 | ype, Print) | | 19b. Mailin | g Address | (Street a | and Numbe | er or Rura | l Route Numi | ber, City | or Town | , State, Zij | o Code) |
| | Health a tem 27 i | | Elaine Gordon / | Daughter | | 3582 | 2 Day | Roa | đ. Da | rlin | gton, | Mars | zlano | 3_210 | 3.4 |
| ore | of He of He fiten | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ | 3 | 20b. Pla | ce of Dispo | sition (Nan | ne of | | D | āte | | | | own, State |
| Ĕ | Pages ment of I ant: If its ury or o | | `4 □Donation 5 □Other (Specify | | Dar | lingto | on Cer | mete | ry | 11-2 | 8-06 | Dar | ling | gton, | Maryland |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examt nat the rollled at Once. | | 21. Signature of Euneral Service Licen | see | | Mc | Name and COMA: | d Addres S Fu | s of Facili neral bury | Hom | e, P.A | ador | n Ma | arvl a | nd 21009 |
| | - | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | plications that caused | the death. | | | | | | | | 17 13. | ary ru | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | Mota | chata | ė | Conc | en | - | | | | | | Onset and Death |
| | /Medical | | resulting in death) | a. Due to (or as a | conseque | ence of): | | | | | | | | - / | months |
| | Examiner | | Sequentially list conditions | b | | | | | | | | | | | |
| | D ## | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a | conseque | ence of): | | | | | | | | | |
| | ecute and -trans | Examiner | that initiated events resulting in death) Last | C | | | | | | | | | | | |
| 760, | te be executed ysician and le burial-transit | E E | rosaning in dodnin Last | Due to (or as a | conseque | ence of): | | | | | | | | | |
| 80 | | dlcai | | d | | | | | | | | | | | |
| 9 X | Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit | by Physiclan/Med | IF FEMALE: | 23c. If yes, outcome of | of pregnance | CV | | | | | | | 004 D | | |
| .O. Box | atten for u | clan | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth 4 Pregnant at | 2 ☐ Fetal d | leath 3 | Ectopic pr | | | | | | | ate of delive onth | ery Day Year |
| o. | the d y the | ıysi | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 9□Unknown | _ | | ouro jop | y/ | | | | | | | |
| J. | s that ned b | y PI | Part II. Dther significant conditions of | ontributing to death bu | t not result | ting in the ur | nderlying ca | ause give | en in Part I | | 23e. Did | tobacco | use cor | tribute to t | he cause of death? |
| rds | w require: been sig should be | | | | | | | | - | | 1 🗆 | Yes | 2200 | 3 🗆 Prot | oably 4 Unknown |
| 00 | s bee | Completed | | | | | | | | | 24a. Wa: | | 24b. | Were auto | opsy findings available |
| Re | The late has age 2 | mo | | | | | | | | | | ormed? | | prior to co death? | mpletion of cause of |
| <u>E</u> | rtifica | e l | 25. Was case referred to medical | | | | | | 26. Place | of Death | 1 ☐ Yes (Check only | 2 N one) | 0 | 1 🗆 Yes | 2 100 |
| _ _ | nysic nis ce direc | To B | examiner? 1 ☐ Yes 2 ♣ No | Hospital: 1 ☐ Inpatier | nt 2 🗆 El | R/Outpatien | t 3 🗆 DO | A Othe | | | ne 5 Res | | 6 □Ot | her (Specit | (y) |
| Division of Vital Records, | or Attending Physicien: The lavefler death. Director: After this certificate has in by the funeral director, page 2 | | 27. Manner of Death 1 Natural 5 Pending | 28a. Date of Injury (Month, Day | y Year) 2 | 8b. Time of | 2 | 8c. Injury Work | at | | 28d. Describe | | | | |
| SIO | eath. or: A the fu | Certification; | 2 Accident investigation | | | | М | | Yes 2□ | No | | | | | |
| <u>=</u> | or Att | TII. | 3 Suicide 6 Could not be determined | 28e. Place of Inju building, etc | ry - At hom . <i>(Specify)</i> | ne, farm, str | et, factory | , office | | 1 | 28f. Location City or To | (Street a | nd Num te) | ber or Rura | al Route Number, |
| | To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the funer | | 200 Comition | | | | | | | | | | | | |
| | Hospital 24 hours Funeral stely filled | edical | 29a. Certifier 1 Certifying Physical Check only 2 Medicel Exemple one) | ysicien: To the best on hiner: On the basis of and manner state | examinatio | edge, death on and/or inv | occurred a restigation, | at the tim in my op | ne, date an pinion, dea | id place, a th occurre | and due to the ed at the time | cause(, date ar | s) and m nd place, | anner as s and due to | stated. the cause(s) |
| | To the within 2 To the complet | Med | 29b. Signature and title of certifier | | .eu. | | 290 | . License | number | | | 29d. D | ate signe | ed (Month. | Day, Year) |
| | F 3 F 8 | | 1 | MD | | | | | | 607 | 7 | | | | 1# 2006 |
| | 10 | | 30. Name and address of person who o | completed cause of de | ath (Item 3 | 23a) (Tvne | Print) | | | | | | | | |
| | 10 | | JOSEPH ANGEL | 0, #205 | . No | 60: | 28 | -A-1 | WOOL | Ro | ail. 60 | BLEZ | AL | R | MD 21014 |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32 Registra | | | 16 5 | | | | | | | | / |

ODICINIAL

DHMH 17 Rev 1/2001

For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 22, 2006 **Physician** 5:45 P Velma Mae Johnson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 1416 Beacon Court Bel Bel Air 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) if Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🖾 F Jun. 27, 1911 Maryland Director 181-01-9282 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2X No Director Maryland Harford <u>Abingdon</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23a 21009 USA 3853-B Memory Lane Funerai filed within 72 hours after death Hygiane. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ∐Yes 2¥∑No Yes.Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes & ☐ No Specify: Specify: 3 Widowed 4 □ Divorced Completed by Year or Dates: White Pages 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiane.
ant: If item 27 le marked other than "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Clerk Retail Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oliver Winfield Preston Adella Amanda Alloway ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1416 Beacon Ct., Bel Air, Maryland 21015 Karen Molnar/ Daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State permit. Pages Department of I Important: If its any injury or of once. 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial 11-27-06 Bel Air, Maryland 21. Signatur of Funeral Service Licensee 22 Name and Address of Facility Home, P. A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final avcinama **Physician** disease or condition resulting in death) /Medical Examiner Equentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 Probably 4 Unknown 1 TYes Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 1 Tyes 25. Was case referred of edical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Standard 6 Other (Specify esidence daughter's 1 🗌 Yes 212 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28c. Injury at Work? 27. Mann f Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 ∏No death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours are:
To the Funeral Direct
To the Funeral Direct á 4 T Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, Xberdeen HD 31. Date filed (Month, Day, agistrar's Signature State Registrar

1elma

| | • | For State Registrar | State of Maryla | | artment of l ertificate of | | Re | g. No. | 37542 |
|---|---------------------|--|---|--|---------------------------------------|---|---|--|--|
| Physic /Med | | Decedent's Name (First, Middle, Las Mabel | "Jackson | | | | 2. Date of Death Month Noue Mb | er 19 200 | 3. Time of Death |
| Exami Funera Director | ner | 5. Social Security Number 6. Social Security Number 1. Social Security | 1000 9109 Lil 3x 7. Age (In y | berhy Ro ers. last birthday Yrs. | Randa | or Location of Death //STOUN If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, 1-20- | Year) 9. Bi | th HMORC County Inhibitor (State or Foreign ountry) Md. |
| /land | | Usual Residence of Decedent 10a. State 10b. County | 10c. | City, Town or L | | | | | 10d. Inside City Limits |
| e Man Ba-f sh | ctor | Md. NA | | Bal | timore | | | | 1 XYes 2 No |
| n with th | ai Dire | 10e. Street and Number 5947 Central 2 | Avenue | | 10f. Zip Code 2 | 1207 | | og. Citizen of What C USA | ountry : |
| be filed within 72 hours effer death with the Maryland Ital Hyglene. Id other than "natural", or items 23a or 28a-f show event, it a Madical Examinar must be notified at | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: | n U.S. 13. | Was Decedent of If Yes, specify Cub | Hispanic Origin? (S van, Mexican, Puert Specify: | pecify Yes or No- o Rican, etc.) | 14. Race - Am Black, Wh Specify: | |
| 72 hou natura | eted | 15. Decedent's Ec | lucation de completed) | (Giv | edent's Usual Occu | during most of wor | rking | 6b. Kind of Busines | s/Industry |
| ad within 72 hours eff giene. er then "naturel", or the Medical Exami | Completed | Elementary/Secondary (0-12) 11th grade | College (1-4or 5+) | | DO NOT use retire | ed) | | Other P | eople Homes |
| nd 2 should be filed the and Mental Hygin 27 is marked other reaumatic event, It raumatic event, It. | Be | 17. Father's Name (First, Middle, Last) | | Duranat | +. | 18. Mother's Nar | ne (First, Middle, M | | ross |
| should be nd Mental marked c | ٦ ر | Elmer 19a. Informant's Name/Relationship (| Type, Print) | Burnet 19b. Mai | | t and Number or Ru | ıral Route Number, | City or Town, State, | Zip Code) |
| end 2 sealth ar n 27 is | | Patricia Nelson | Niec | | 12 Nuttal | Ave., E | Edgewood | , | 21040 |
| ages 1 nt of Hi | | 20a. Method of Disposition 1 ☑ Kurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control | Removal from State | cemetery, cre | osition (Name of ematory or other pla | 1 | Date 2 | oc. Location - City o | |
| permit. Peges 1 end 2 should by Depertment of Health and Menta important: If Item 27 is marked any Injury or other traumatite a | | 21. Signature of Funeral Service Licer | | | us Mem. | ess of Facility | March I | F.H. East | |
| | | 23a. Part 1. Enter the disease, or com | plications that caused the d | leath. Do not er | 1101 E. | | | Baltimore, | Approximate Interval Between |
| ficate be executed Wedgica Thysicien end Figure is the burial-transit | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a conduct. Due to (or as a conduct. Due to (or as a conduct.) | sequence of): | ementi | 9 | | | |
| the ettending | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown | etal death 3 | □Ectopic pregnand □ Other (specify) | Э | | 23d. Date of do Month | elivery Day Year |
| s tha gned be de | þ. | Part II. Other significant conditions of | ontributing to death but not | resulting in the | underlying cause g | iven in Part I. | 23e. Did tob | | to the cause of death? Probably 4 □Unknown |
| te h | Completed | | | | | | | prior to death? | |
| OI VICAL Physician: 1 rthis certificel ral director, p | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: 1 ☐ Inpatient | 2 ER/Outpatie | ent 3 DOA | hon - | ath <i>(Check only one</i> dome 5 \to Reside | nce 6 □Other (Sp | ecify) |
| Attending Phor death. ector: After the by the funeral | | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day Yea | r) 28b. Time Injury | W | uryat ork?]Yes 2∐No | 28d. Describe ho | w injury occurred | |
| = = = - | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - A building, etc. (Sp | At home, farm, s | treet, factory, office | | 28f. Location (Str City or Town | | Rural Route Number, |
| Hospital 24 hours a Funeral C | Medical | | niner: On the best of my and manner stated. | | | | | | |
| To the Hospitel of within 24 hours af To the Funeral D completely filled in | Mec | 29b. Signature and title of centred | Med stated. | | 29c. Licer | 056414 | 29 | ed. Date signed (Mon | nth, Day, Year) -06 |
| 3 | | 30. Na pa a addres if person who | complete cause of death | MD, D | a, Print) 1974 910 | og Libert | y Road, | Randall | -06 fown, MD 21133 |
| S Regis | tate strar | 31. Date filed (Month Day, Year) | 32. Registrar's S | ignature | ونكله | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 24, 2006 November George Gene Knupp 9:10 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Gilchrist Center Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 157M 2□ F 1933 Director 225-40-0322 27, 73 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 🖾 No Director Rileyville Page 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 425 Countryside Lane 22650 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 1 No If Yes, Give 1952 - Year or Dates: 1956 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status the Medical Examiner filed within 72 hours after 1 □ Never Married 2 □ Married "natural", or altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Customer Engineer Computer Pages 1 and 2 should be filed vent of Health and Mental Hygidint: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Casper Knupp Gladys Hayton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa J. Shapiro 3410 Dogwood Drive, Ellicott City, MD (Daughter) 21042 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once, 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 11-27-06 Alexandria, VA 21. Sign and of Funeral Service Esenses 22. Name and Address of Facility The Bradley Funeral Home, Inc. 187 E. Main St., PO Box 442, Luray, VA 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and De liminediate Cause (Final bisease or condition resulting in death) **Physician** mouth /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1∐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: SA No 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 1 Inpatient this 27. Manner of Death To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕊 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

1)

31. Date filed (*Month, Day, Year*) **NOV 2** 8 2006

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6601 N Chades Street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | 4 | For State | State of | Maryland | | rtment of H | | id Men | | 000 | 16 | 2751.1. |
|-------------|---|-------------------|--|--------------------------------------|-----------------------------------|--------------------------------|---|------------------------------------|---|---|-------------------------|-------------------|---------------------------------|
| | | | Registrar 1. Decedent's Name (First, Middle | (act) | | | lilicate of i | Dealli | 2.1 | Reg Date of Death | . No. <u> </u> | 10 | 3. Time of Death |
| | Physicia | an | | | ** | | | | 1 | Month | | ear | |
| | /Medic | al . | Donald | George | | ammere | t 4b. City, Town, or | L section of D | | ovember | 26, 20 4c. County of | | 9:15am M |
| | Examin | er | 4a. Facility Name (If not institution | | ber) | | | | | | Balti | | |
| 17. | | Щ | 1403 Chippend 5. Social Security Number | | 7. Age (In yrs. la | ast hirthday) | If Under 1 Year | erville | | Date of Birth | | | ace (State or Foreign |
| | Funeral | | | 1 M 2 □ F | | Yrs. | Months Days | | Min. (| Date of Birth Month, Day, Y ${ m uly} \ 14$, | ear) | Count | yland |
| | Director | - | 215-30-9434 Usual Residence of Decedent | | 73 | | | | J | ury 14, | 1733 | rial. | ylanu |
| | land ow | | 10a. State 10b. County | | 10c. City | , Town or Loc | cation | | | | | 10 | d. Inside City Limits |
| | Mary f sh | ţō | Maryland Balti | more | | Tutho | rville | | | | | | 1 □ Yes 2 No |
| | the 28a | Director | 10e. Street and Number | .more | | пасне | 10f. Zip Code | | | 100 | . Citizen of Wha | at Count | ry? |
| | 3a or | 0 | 1403 Chippendal | e Poad | | | 21 | 093 | | | USA | | |
| | hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notifiled at | Funeral | 11. Marital Status | 12. Was Deced | dent Ever in U.S | S. 13. V | Vas Decedent of H Yes, specify Cuba | | ? (Specify | Yes or No- | 14. Race - | | |
| 0 | or Ite | | 1 ☐ Never Married 2 ☑ Marr | Armed Fore | 2 □ No | | Yes 2X No | | ruerio nica | ii, etc.) | | White, e | ic. |
| 2000 | urs a al", o Exant | by | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Da | e ites: | ' | ∐ Yes ZLALINO | Specify: | | | Specify: | Wh | ite |
| | 2 ho | Completed | 15. Deceden | t's Education st grade completed) | | 16a. Deced | ent's Usual Occup | ation | f working | 16 | b. Kind of Busin | ness/Ind | ustry |
| <u>7</u> | hin 7 e. an "r Med | ple | Elementary/Secondary (0-12) | College (1- | -4or 5+) | | kind of work done OO NOT use retired | | · ····································· | | | | |
| Z | d wit | 50 | 12 | 04 | | Day- | Care Dir | | | | Day-(| are | |
| <u> </u> | al Hy al Hy l oth | Be | 17. Father's Name (First, Middle, | Last) | | | | 18. Mother's | Name (Fir | rst, Middle, Ma | iden Surname) | | |
| /land | arked | 2 | George Jo | hn | Kamme | rer | | M | ildre | d | _Leff1e | er | |
| Mar | iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If item 27 Is marked other than "natural", or items 23a or 28a-f show it item 27 Is marked other than "natural", or items to must be notified at or other traumatic event, the Medical Examiner must be notified at | | 19a. Informant's Name/Relations | hip (Type. Print) | | 19b. Mailin | g Address (Street | and Number of | or Rural Ro | ute Number, (| City or Town, St | ate, Zip | Code) |
| | 1 and 2 Health tem 27 l | | Janice A. Kamme | rer/Wife_ | | | Chippen | dale Ro | | | | | 21093 |
| <u>9</u> | of He | | 20a. Method of Disposition 1 | 3 □Removal from 5 | | lace of Dispo emetery, cren | sition (Name of natory or other plac | ce) | Date | 20 | c. Location - Ci | ty or To | vn, State |
| altimore, | Pag nent ant: I | | 4 Donation 5 Other (S | | Dru | | dge Cemet | | | | | | Maryland |
| Ball | permit. Pages 1 Department of H Important: If ite any injury or ot once. | | 21. Strong of Funeral Service | Licy Med | |) 22 | Name and Addre Lemmon F 10 W. Pa | ess of Facility uneral donia | Home | of Dul | laney Va | 11e | y Inc. 093 |
| | | | 23a. Part1 Enter the disease, or shook, or heart failure. List | | aused the death | | | | | | | Ī | Approximate Interval Between |
| | Physician | | Immediate Cause (Final | only one cause on a | EDTE | USIVE | CARDIO | UASO | ULAK | 2 DI | SEASE | | Onset and Death YEARS |
| | /Medical Examiner | | disease r condition resulting death | | or as a consequ | | | | | | | | |
| | | <u>.</u> | Sequentially list conditions, | b. — Due to (| or as a consequ | uence of): | | | | | | | |
| T | ted sit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | < | | | | | | | | | |
| / | xecul and Il-trar | xan | that initiated events resulting in death) Last | c | or as a consequ | uence of): | | | | | | | |
| 8/60 | cate be executed ohysician and the burial-transit | | | | | | | | | | | | |
| 8 | icate phys s the | gic | | d | | | | | | | | | |
| × | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/Medical | IF FEMALE: | 23c. If yes, out | come pf pregna | апсу | | | | | 23d. Date | of delive | rv |
| ROX | eath atter for u | ciar | 23b. Was decedent pregnant in the past 12 months? | | irth 2 □ Feta ant at time of d | | Ectopic pregnanc Other (specify) | У | | | Mont | | Day Year |
| o. | at the de by the | ysi | 1 □ Yes 2 □ No 9 □ Unknown | 9□Unkno | | | | | | | | | |
| J. | that ed by deta | | Part II. Other significant conditi | ons contributing to de | eath but not resu | ulting in the u | nderlying cause giv | en in Part I. | | 23e. Did toba | cco use contrib | ute to th | e cause of death? |
| g | uires sign d be | d by | | | | | | | | 1 ☐ Yes | 2 No 3 | ☐ Prob | abiy 4 Dunknown |
| Records, | w requires that been signed to should be deta | Completed | | | | | | | | 24a. Was an | 24b. We | ere autor | osy findings available |
| ž | has ge 2 | mp | | | | | | | | autopsy perform 1 Yes 2 | pri | or to con ath? | npletion of cause of |
| | | | | | | | | | | | | Yes | 2 □ No |
| Vital | Attending Physiclan: The lar r death. ector: Affer this certificate has by the funeral director, page 2 | B | 25. Was case referred to medical examiner? | Hoenital: | | ED/0.1 | | or. | | heck only one, | | , o | |
| ō | Phys r this ral di | - To | 1 ☐ Yes 2 ☒ No 27. Manner of Death | 28a. Date (| npatient 2 of Injury | 28b. Time o | I SUIDON | 4 🗆 Nuis | | | ce 6 Other | | <u></u> |
| E C | ding F h. After funera | ion | 1X Natural 5 ☐ Pendi | /8 / a m f | th, Day Year) | Injury | Wo | rk?]Yes 2∐No | | | ,- , | | |
| S | Attener death | cal | 3 Suicide 6 Could | not be 280 Place | of injury - At ho | l ome, farm, str | eet, factory, office | - == | | Location (Stre | et and Number | or Rura | Route Number, |
| Division or | after Dire | Certification: | 4 ☐ Homicide determ | buildir | ng, etc. (Specif | (y) | | | | City or Town, | State) | | |
| | spita nours neral / filled | | 29a. Certifler 1 Certifyi | ng Physician: To the | best of my kno | wiedge, deat | h occurred at the t | ime, date and | place, and | due to the car | use(s) and man | ner as st | ated. |
| | To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the | Medical | one) | | asis of examina ner stated. | ation and/or in | | | n occurred a | | | | |
| | To To | Σ | 29b. Signature and title of certific | | 0 | 11 | 29c. Licens | | ~ ~ | | d. Date signed | wonth, i | Jay, rear) |
| | 1. 1 | | John ! | · Wire | Luce | | 100 | 0349. | 2 2 | | Novembe | r 27 | , 2006 |
| 1 | (4) | | 30. Name and address of persor | | | | | | _ | | 01001 | | |
| | - | | John T. Evelius | | 600 Os1 legistrar's Signa | aturo | ve, suit | e 308, | Tows | on, MD | 21204 | | |
| | Sta Regist | ate rar | 31. Date filed (Month, Day, Year NOV 2 8 | 2006 | egioriai s olyna | & And | all i | | | | | | |
| | ricgist | T I | 1404 9 0 | LUUU Breight | SHAM MINING | See Long | But. | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2006 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year NOVEMBER 15, 2006 ARIANA TRAILL KENETY 9:21P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Saint Joseph Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | NOV • 1 4 , 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 □ M 2 🔀 F NEW YORK 067-18-9485 84 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits BALTIMORE COCKEYSVILLE 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 869 IVY HILL ROAD 21030 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No WHITE Specify: 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ARIANA MCELFRESH ALAN ARNOLD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 1942 YLAND 19a. Informant's Name/Relationship (Type. Print) WILLIAM KENETY son 2103 SPENCER RD. SILVER SPRING, 20910 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State MOUNT OLIVET 1 Durial 2 □ Cremation 3 □ Removal from State 11/24/2006 FREDERICK, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS, CO. 16924 YORK RD. MONKTON, MD 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAY ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): TRIPLE VESSEL CORONARY ARTERY DISEASE YEARS Due to (or as a consequence of): CHRONIC OBSTRUCTIVE FULMONARY DISEASE YEARS Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknow 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

the burial-tran

attending physician for use as the buria

ed by the a

page 2 s

funeral director.

ours after death.

neral Director: A
filled in by the fu

To the Hospital c within 24 hours af To the Funeral D Acompletely filled i

ģ

Completed

Be

Certification: To

Medical

The law requires that the death certificate be executed

Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ir than "natural", or Items 23a or the Medical Examiner must be

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Innportant: If them 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Exercisione.

Maryland 21215-0036

saltimore,

death

Director

Funeral

\$

Completed

Be

ဂ္

MD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Examiner Physician/Medical

2 No

1 ☐ Yes

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy perform

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 11 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier

1 ehla

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) M.D. 76. 32 Registrar's Signature OSLER DRIVE TOWSON, MARYLAND 21204 7601

D41410

State Registrar

determined



DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registramend #5 Per FH G852 12/04/06 rtificate of Death Date of Death
 Month Year **Physician** 2006 Kreiner 21, 12:03 AM James November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 212-20-9438 **Funeral** Hours Days 1⊠M 2□F Director 212-20-1938 June 12, 1924 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Harford Forest Hill Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21050 1867 Trudeau Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1. ☐ Yes 2 ☐ No If Yes, Give Yorean Year or Dates: Conflict 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wire Department of Health and Mental Hygien Important: If Item 27 Is marked other the any Injury or other traumatic event, the once. Splicer Gas & Electric Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Kreiner Anna Marie Leonard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Evelyn Marie Kreiner, Wife 1867 Trudeau Drive Forest Hill, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) N. cv, 25°, 2006 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion United Methodist Cem. Bel Air, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Parl1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** entho /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) as been signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No r this certificate has I autopsy performed? 2 **N**o 1 | Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. injury at Work? Certification: 1 Natural injury 5 □ Pendina 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) No vember 21, 2006 (mg) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(1) A Rilsy Charles St. Bolto. Md 212d) 6701

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

32 Registrar's Signature

2006

8

| | | 1 - For State Registrar | State of Maryla | and / De | epartment of Certificate o | Health of Death |) | Reg | 2006 | 37547 |
|--|-----------------|--|--|---------------------------------------|---|-----------------------------------|-------------------------------|--|---|--|
| Physic | | Decedent's Name (First, Middle, Last, | | Leonar | d Krug | | | Date of Death Month November | Day Year r 23,2006 | 3. Time of Death 11:59 P ^M |
| /Med Exami | | 4a. Facility Name (If not institution, give | street and number) | | 4b. City, Town | , or Location | of Death | | 4c. County of Dea | ath |
| | | 8328 Bletzer Road | | | Dı | ındalk | | | Ва | ltimore |
| Funeral Director | | 220-30-6611 | 7. Age (In y 2x M 2□ F 70 | rs. last birthe Yr | Months Day | | Min | Date of Birth (Month, Day, Y 19. 14, 1 | 'ear) C | rthplace (State or Foreign country) ryLand |
| pus * | | Usual Residence of Decedent 10a, State 10b, County | 10c. | City, Town | or Location | | | | | 10d. Inside City Limits |
| aryls eho | 1 | | | , | | | т | oundalk | | 1 ☐ Yes 2 ☑No |
| death with the Maryland ims 23a or 28e-f ehow rmst be notified at | Director | Maryland Balti 10e. Street and Number | rmore | | 10f. Zip Cod | | | | , Citizen of What C | Country? |
| with a | D | 8328 Bletzer Roa | a d | | . 101. 21p Cou | 21222 | 2 | | | |
| s 23 | era | | 12. Was Decedent Ever is | 118 | 13 Was Decedent | | | | Jnited St 14. Race - Am | |
| ZTZTS-UU30 4 within 72 hours after death with the Marylar jiene "natural", or Nems 23a or 28e-1 show the Medical Examinar must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced | Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: | 70.0. | 13. Was Decedent of If Yes, specify C | | | an, etc.) | Black, Wh | |
| 72 ho | ted | 15. Decedent's Edu (Specify only highest grad | cation | 16a. D | ecedent's Usual Oc Give kind of work do | cupation | st of working | 16 | b. Kind of Business | s/Industry |
| within 7 within 7 then "in Med | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | ife. DO NOT use rel | ired) | si di wonting | | a. 1 = | 3 |
| d with | Our | 12 Years | | | Machir | nist | | | Steel In | dustry |
| | Be | 17. Father's Name (First, Middle, Last) | | | | 18. Moth | ier's Name (F | irst, Middle, Ma | iden Sumame) | |
| YIZAND ould be fill Mental H; warked oth | To E | Frederick Krug | | | | | Ag | gnes Bai | ust | |
| Mary id 2 sho ith and 1 27 is ma | | 19a. Informant's Name/Relationship (Ty | rpe, Print) | 19b. N | Mailing Address (Stre | et and Numb | er or Rural R | loute Number, C | City or Town, State, | Zip Code) |
| and 2 ealth m 27 I | | Mrs. Patricia Kru | (WITE) | | 8 Bletzer | | Dunda | alk, Mar | yland 2 | 1222 |
| w = = | | 20a. Method of Disposition | 20 | b. Place of C | isposition (Name of crematory or other) | olace) | Date | 20 | c. Location - City o | r Town, State |
| Baltimor permit. Pages Department of P Importent: If Ite any Injury or of once. | | 1 ³ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation / 5 ☐ Other (Specify) | Manioval Holli State | 11 1 | of Faith | į. | 11/27 | /2006 | Baltimo | re, Maryland |
| Mit. Daring | | 21. Signature of Funeral Service | | /// | 22. Name and Ad | dress of Facili | ity | | | |
| n ages | | 1 /al 111 | 1200 | 1 | Duda-Ruc 7922 Wis | k Fune | eral Ho | ome of L Lalk. Ma | oundalk, | Inc. 21222 |
| | | 23a. Part1. Enter the disease, or compl shock, or heart failure. List only or | ications that caused the d | eath. Do no | t enter the mode of o | tying, such as | s cardiac or re | espiratory arres | t, | Approximate Interval Between |
| Physician | | Immediate Cause (Final | A A | -/- | 51405 | . 1 | | | | Onset and Death |
| /Medical | | disease or condition resulting in death) | a Due to (or as a com | - | | , J | | | | |
| Examiner | • | | 220 10 (0) 20 2 00 | | , | | | | | |
| 1175 | ē | Sequentially list conditions, if any, leading to animodiate cause. Enter Underlying Cause (Disease or injury | Due to (or as a nor: | sequanda of) | | | | | | |
| uted | 들 | Cause (Disease or injury that initiated events | | | | | | | | |
| exec n an | Exa | resulting in death) Last | Due to (or as a con | sequence of |): | | | | | |
| ficate be executed physician and streets the burial-transition | edical Examiner | l l | 1 | | | | | | | |
| ificat g phy | | | | | | | | | | 1 |
| at the death certification by the attending of | by Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown | etal death | 3 □Ectopic pregna 5 □ Other (specify, | | | | 23d. Date of de Month | elivery Day Year |
| - E 28 | P | Part II. Other significant conditions con | ntributing to death but not | resulting in t | he underlying cause | given in Part | 1. | 23e. Did toba | cco use contribute | to the cause of death? |
| signe at be | | | | · · · · · · · · · · · · · · · · · · · | and any mig dated | g | | | | robably 4 Unknown |
| COLDS, P. w requires that s been signed b should be detailed. | ompleted | | | | | | | | | |
| Vital Hecords, rsicien: The law requires t s certificate has been signe director, page 2 should be o | du | | | | | | | 24a. Was an autopsy | prior to | utopsy findings available completion of cause of |
| - G CT | S | | | | | | | performe | | s 2□ No |
| VISION OT VITA Attending Physicien: r death. ector: Atter this certific by the funeral director, | Be | 25. Was case referred to medical examiner? | T | | | | e of Death (C | Check only one) | | |
| OT \ Physical rethis of oral directions or the oral direction or the oral directions or the oral directions or the oral directions or the oral directions or the oral direction or the oral directions or the oral directions or the oral direction or the oral directions or the oral direction or | ို | 1 195 AC NO | | | ationic SLI DOA | | | | ce 6 ☐Other (Sp | ecify) |
| On C | ü | 27. Mann of Death 1 atural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year | 28b. Tin | | njury at Vork? | | Describe how | injury occurred | |
| ISIO Mendi death. ctor: A y the fu | cat | 2 Accident investigation | | | M 1 | ☐Yes 2☐ |]No | | | |
| DIVISION or Attending after death. Director: Afte | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - A building, etc. (Sp | t home, farn ecify) | n, street, factory, offi- | СӨ | 28f | Location (Stre City or Town, | et and Number or F State) | Rural Route Number, |
| Epitet or ours afte nerel Dir filled in | | | 1 | | | | | | | |
| 4 4 P 9 | Medical | 29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami | sician: To the best of my ner: On the basis of exam and manner stated. | knowledge, on and/ | death occurred at the or investigation, in m | e time, date ar y opinion, dea | nd place, and ath occurred | due to the cau at the time, date | se(s) and manner a e and place, and du | s stated. e to the cause(s) |
| To the within 2 To the complete | ž | 29b. Signature and title of certifier | | | 29c. Lice | ense number | | 290 | I. Date signed (Mor | nth, Dey, Year) |
| . ,,,,, | | 1 Ulasson | ~~ | | 0 | 005918 | 7 | | 11/24/06 | • |
| 1 | | 30. Name and address of person who co | ompleted cause of death (| Item 23a) (T | vpe. Print) | | | | | |
| (0 | | Seren Barron | 32. Registrar's Si | 2 \~ | 40 M 51 | B | . Hom | UK NI | 2/21/ | |
| S | ate | 31. Date filed (Month, Day, Year) | 32. Registrar's Si | gnature | - | 4.5 | 2.27 | | | |
| Regis | | NOV 2 8 2 | 006 | 10 | Acc. 10 | | | | | |
| DHMH 17 Rev 1 | 2001 | | - Joseph S | 1000 | | | | | | |

ORIGINAL

| | | - | - For Amend #8 Per | State of Maryland FH G861 11/3 | 1 / Depa 50 / 06 <i>e</i> / | irtment of H | ealth and M Death | ental Hy | giene 006 | 37548 |
|---------------------|--|----------------|--|---|-----------------------------------|---|---|-----------------------------------|---|--|
| - | 200 | | Decedent's Name (First, Middle, Last) | | | | | 2. Date of De | ath | 3. Time of Death |
| | Physicia /Medic | | Evelyn Jones K | inney | | | | Novemb | er 26, 2006 | 8:00 A M |
| | Examin | _ | 4a. Facility Name (If not institution, give st | | | | Location of Death | | 4c. County of Deat | |
| N. A. | | | Wilson Health Can 5. Social Security Number 6. Sex | re Center 7. Age (In yrs. la | ant hirthday) | Gaithe If Under 1 Year | ersburg | 9 Date of Bir | Montgo 5-22-1918 Birt | |
| | Funeral Director | | | M 2 1 88 | Yrs. | Months Days | Hours Min. | (Month, Da | y, Year) Co | ginia |
| K. T. | | | Usual Residence of Decedent | | | | | Tidy 200 | | |
| | urylan show | b., | 10a. State 10b. County | | , Town or Lo | | | | | 10d. Inside City Limits 1X Yes 2 □ No |
| | Sa-f | Director | Maryland Montgomer | y Gai | thers | 10f. Zip Code | | | 10g. Citizen of What Co | |
| | with the | | 10e. Street and Number 301 Russell Avenue | #401N | | 2087 | 7 | | United St | |
| | ne 23 | Funeral | | 2. Was Decedent Ever in U.S | 3. 13. \ | Vas Decedent of H | ispanic Origin? (Spe | cify Yes or No | - 14. Race - Ame | ncan Indian, |
| Maryland 21215-0036 | d within 72 hours after death with the Maryland jiene. Jiene. Than "natural", or Iteme 23a or 28a-f ehow triban "natural", or Iteme 21a or 28a-f ehow | by | 1 ☐ Never Married 2 ☐ Married 3 📉 Widowed 4 ☐ Divorced | Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | | fYes, specify Cuba | n, Mexican, Puerto I | Hican, etc.) | Black, White | hite |
| 2-0 | 72 ho | Completed | 15. Decedent's Education (Specify only highest grade | | (Give | dent's Usual Occupa | during most of working | n <i>g</i> | 16b. Kind of Business/ | ndustry |
| 21 | within ene. then " | mple | Elementary/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use retired Food Servi |) | | Department | Store |
| 12 | e filed within al Hygiene. other than ' | | 12 17. Father's Name (First, Middle, Last) | | Dakery | rood Servi | | (First, Middle | , Maiden Sumame) | Deole |
| ano | 0 to 0 | To Be | Chester H. Jones | | | | Virgini | e Mary | Furst | |
| ary | s 1 and 2 should f Health and Mer Item 27 is marke other traumatic | F | 19a. Informant's Name/Relationship (Typ | e, Print) | 19b. Mailir | ng Address (Street | | | er, City or Town, State, 2 | lip Code) |
| _ | 1 and 2 Health a em 27 is | | George Patrick Kin | | The second second | | ld Road, | Bethesd | la, Maryland | |
| ore | of He | | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re | moval from State | ametery, crer | sition (Name of natory or other plac | -/ | ber 6, | 20c. Location - City or | |
| ij | Pag ment tent: | | 4 □ Donation 5 □ Other (Specify) | Arli | _ | National Ce | | | | , Virginia |
| Baltimore, | permit. Pages 1 a Department of He Importent: If Item any injury or oth | | 21. Signature of Funeral Service License William Company Co | shilly MO11 | / 3 75 | 57 Wiscons | in Avenue, | Bethesda | , Maryland 20 | evy Chase, Inc. 314 |
| | Physician | | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final | | | | | | rrest, | Approximate Interval Between Onset and Death |
| 1 | /Medical | | disease or condition resulting in death) | Due to (or as a consequ | | arean c | iceident | - | | acuts |
| | Examiner | | Swinestally for conditions 5 | vascul | an d | tsoase | | | | years |
| , | od sit | Iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequ | ience of): | | | | | |
| V | and and Il-tran | Examine | that initiated events c. resulting in death) Last | Due to (or as a consequ | ience of): | | _ | | | y-000-5 |
| 8760, | cate be executed chysicien and the burial-transit | dical E | d | | | | | | | |
| 9 | ificate g phy as the | 0 | | | | | | | | |
| O. Box | The law requires that the death certificate be executed tae been signed by the attending physicien and bage 2 should be detached for use as the burial-transit | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | ic. If yes, outcome of pregna 1∐Live birth 2 ∏Fetal 4∐Pregnant at time of de 9∏Unknown | death 3[| Ectopic pregnancy Other (specify) | , | | 23d. Date of del Month | ivery Day Year |
| Δ, | es that the digned by the be detached | | Part II. Other significant conditions conf | ributing to death but not resu | ılting in the u | nderlying cause giv | en in Part I. | 23e. Did | tobacco use contribute to | the cause of death? |
| rds | w requires been sign should be | d be | Hyportension | Mypothyn | rethic | b | | 10 | Yes 2₽No 3□Pr | obably 4 DUnknown |
| Vital Records, | The law requate has been page 2 shoul | Completed by | | | | | | 24a. Was auto perfe | psy prior to death? | topsy findings available completion of cause of |
| ital | | 0 | 25. Was case referred to medical | | | | 26. Place of Death | | | |
| of V | ys dis | ToB | examiner? 1 ☐ Yes 2 ☐ No He | ospital: 1 Inpatient 2 | ER/Outpatier | | 4 Mursing Ho | me 5□Res | dence 6 Other (Spe | cify) |
| | Jing Pl | | 27. Manner of Death 1 Natural 5 Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time o | Wor | | 28d. Describe | how injury occurred | |
| Sio | Attending in death. • ctor: After by the fune | cat | 2 Accident investigation 3 Suicide 6 Could not be | 30 - Pines of Injury At he | mo farm et | | Yes 2 □ No | 28f Location | Street and Number or Ri | ral Route Number |
| Division | after of Direction by | Certification; | 4 Homicide determined | 28e. Place of Injury - At he building, etc. (Specify | /) | eet, factory, office | | | wn, State) | nar noute reunios, |
| _ | To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral | edical C | 29a. Certifier 1 Certifying Phys (Check only one) | ician: To the best of my kno- er: On the basis of examinal and manner stated. | wledge, deat tion and/or in | h occurred at the tir vestigation, in my o | ne, date and place, pinion, death occurr | and due to the ed at the time, | cause(s) and manner as date and place, and due | stated. to the cause(s) |
| | To the | Me | 29b. Signature and title of certifier | | | 29c. Licens | e number | | 29d. Date signed (Mont | h, Day, Year) |
| | / | | Ca Olahamur | lua mo | | 041 | 1794 | | November | -26,200Le |
| | 15 | | 30. Name and address of person who con | mpl- ed cause of death (Item | 23a) (Type, | Print) | | 4.4.4 | | |
| | 1 | | P. Callahan-hyo | 1, MP 911 | llus | Eoil When | ue Ga | thers. | burg, MD | 20179 |
| | St Regist | ate rar | 31. Date filed (Month, Day, Year) | 32. Hagistrar's Signa | ture | parti | | | | n, Day, Year) 26, 2006 20879 |

Please Type or Print in Black Indelible lok. Ensure All Copies Are Legible. amend item 12 per fh 2861 11-28-06 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Ullan 11 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **BALTIMORE** 10 GREENLEA DRIVE BALTIMORE 7. Age (In yrs. last birthday)

89

Yrs. If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 218-01-8023 1 M M 2 □ F MD Director 11/16/1917 Usual Residence of Decedent with the Maryland show i 10c. City, Town or Location 10d. Inside Cify Limits 10a. State 10b. County ral", or Items 23a or 28a-f shov Examiner must be notified at BALTIMORE BALTIMORE 1 □Yes 2 X No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 10 GREENLEA DRIVE U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 文字 2 文章 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □ Yes 2 No Specify. 2 Specify: WHITE 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the PRESIDENT APPAREL MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental F Important; If Item 27 is marked old any Injury or other traumatic ever once. KATZENBERG, SR. ADELE LONG ALEXANDER S. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ROGER KATZENBERG / SON 1014 WINDSOR ROAD - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW CONG | 11/27/2006 REISTERSTOWN, MD 4 □ Donation 5 □ Other (Specify) Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dadse on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of highly that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical the 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Tes 2 | No 3 Probably 4 Donknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 Ho Division or Vital 25. Was case referred to medical examiner? 26. Place of Death Check onl o Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ NO Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Funeral D within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2006 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NÖVEMBERºŽ2, 2ŬŨ6 **Physician** KORSCHUN ALAN Μ. 7:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOLY CROSS HEALTH CENTER BURTONSVILLE MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 03/26/1935 5. Social Security Number Birthplace (State or Foreign Country)
 NC **Funeral** 1**∑**M 2□ F 241-54-2709 NC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other than "neturel", or Iteme 23e or 28e-1 show other treumetic event, the <u>Medical Examiner must be notified at</u> Director MD HOWARD WOODBINE 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16180 ED WARFIELD ROAD 21797 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SALES PITNEY-BOWES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be KORSCHUN CHARLES BELLE MILLER ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 le eny injury or other tret once. SUSAN CROWE / DAUGHTER 16180 ED WARFIELD ROAD - WOODBINE, MD 21797 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM. 11/24/06 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Advanced Dementio disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Entar lineary in Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ◯ No autopsy performed? 1 Yes 2. No Be 25. Was case referred to medical 26. Place of Death Check on one) examiner Other: P 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 2 Accident investigation 1 Yes 2 No after death in by the 1 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funerel C 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D0054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogaville, 1220 HEAST TOUR ROad, such 250, TOUSON MD 21286 31. Date filed (Month, Day, Year) 34. Registrar's Signature Speciel State Registrar NOV 2 8 2006

Mary Kasprzak 06-08832 UNK UNK

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

| | | - For State Registrar | e or iviaryland / L | • | cate of Death | ina monta | _ | eg. No. 200 | 6 2755 |
|--|---------------|--|--|---------------------|---|--------------------|---------------------------------------|---------------------------------------|--------------------------------------|
| Physiciar Medical Examin | | 1. Decedent's Name (First, Middle,L Mary Cecil | | 27 o le | | | 2. Date of Death Month November | | 3. Time of Death 2145 hrs |
| Medical Examina | - | 4a. Facility Name (if not institution, or | | Zak | 4b. City. Town. | or Location of De | | 19, 2006 4c. County of Dea | |
| | | 508 South Streeper Stre | | | Baltimore | | | , | |
| Funeral | - 1 | 010 /6 0670 | | n yrs. last bi | | | | h(MM/DD/YYYY) 9. B | ion |
| Director | | | M 2 XF | 59 | Yrs. | ays Hours | Min. Aug12 | ,1947 | ountMaryland |
| áu iu | H | Usual Residence of Decedent 10a State 10b. County | 10 | c. City, Tow | n or Location | | | | 10d Inside City Limits |
| how s | | Md. n/a | | | timore | | | | 1 Yes 2 No |
| ne Maryland or 28a-f show any fied at once. | Director | 10e, Street and Number | | | 10f. Zip Code | 9 | 10 | g Citizen of What Co | untry? |
| 3a or | | 508 South Stre | eper Stree | et | 2 | 1224 | | USA | |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumates. | Funeral | 11, Marital Status 1 Never Married 2 Marrie | 12. Was Decedent Even Armed Forces? | er in U.S. | 13. Was Decedent of If Yes, specify Cul | | | 14. Race - Ame White, etc. | erican Indian, Black, |
| ier dea | | | 1 Yes 2 2 | No | 1 Yes 2x | No specify: | | Specify: WI | nite |
| urs afi rtural | 핡 | 15. Decedent's Education (Specify | or Dates: | ited) 16a | . Decedent's Usual Occu | pation (Give kind | | 16b. Kind of Business | |
| 1215-0036 Id be filed within 72 hours after fental Hygiene arked other than "natural"; event, the Medical Examiner | Completed | Elementary/Secondary (0-12) | College (1-4 or 5+) | | during most of working | life. DO NOT use | retired) | | |
| 21215-0036 Juld be filed within 7 Mental Hygiene Hygiene in marked other than ic event, the Medical | 틹 | 10th 17. Father's Name (First, Middle, La | -4\ | | Office W | | (pa) A A A A A | Office | |
| 115- | ا د ا | George Kasprz | | | | Antoin | ette Mon | iewshi | |
| 212 buld bould by Ment i mark | | 19a. Informant's Name/Relationship | | 19 | 9b. Mailing Address (St | reet and Number | ina Mon or Rural Route Numl | ber, City or Town, Stat | te, Zıp Code) |
| and 2 should stealth and N ten 27 is in traumatic | 1 | Mr & Mrs Leo D | udek | | 7344 Mancl | nester | Road Ba | ltimore, | Md. 21222 or Town, State |
| nore, ages 1 an nt of Hea nt: If iter other tra | | 20a. Method of Disposition 1 | Removal from State | 20b. Place crema | of Disposition (Name of atory or other place) | cemetery, | Date | 20c. Location - City of | or Town, State |
| Baltimore, Pages I ar Department of Hee important: If iten injury or other tr | | 4 Donation 5 Other Speci | fy: | St. | Stanislaus | s Cem 1 | 1-25-06 | Baltimor | e,Maryland |
| Bait permit. Departi Impor injury | - | 21. Signature of Funeral Service Lic | ensee | | 22. Name and Addr | ess of Facility a | czorowsl | ki Funera | 1 Home, PA |
| Physician | + | 23a. Part I. Enter the disease, or cor | | death. Do r | not enter the mode of dyin | ng, such as cardia | ac or respiratory arre | timore, Nest, shock, or heart | Approximate Interval |
| /Medical Examiner | i | failure. List only one cause on Immediate Cause (Final disease | a Smoke Inhalation | | | | | | Between Onset and Death |
| 2/(4/11/10) | | or condition resulting in death) | Due to (or as a consequ | ence of): | | | | | |
| | [발 | Sequentially list conditions, if any, leading to immediate | Due to (or as a consequ | ence of): | | | | | _ |
| | Examiner | cause. Enter Underlying Cause (Disease or Injury that initiated | c. Due to (or as a consequ | ence of): | | | ±80 | | |
| executed an and al - transit | - 1 | events resulting in death) Last | d. | , | | | | | |
| 0) '7: '7 | Medical | UNPENDED | X AMENDED 18 P | er fh | g862 12-4-0 | % v t | | | |
| 760, ficate be g physici the buri | | IF FEMALE: 3b. Was decedent pregnant in the | 23c. If yes, outcome of | of pregnancy | | 2 | | 23d Date of delive | |
| Box 687 e death certific the attending ed for use as ti | sıcıan | past 12 months? | 1 Live birth 4 Pregnant at tim | e of death | Fetal deathOther (Specify) | 3 Ectopic pre | gnancy | Month | Day Year |
| Bo ne deat the at | 51 | 1 Yes 2 No 9 Unkno | a ournown | | | | | | |
| Division of Vital Records, P.O. E tal or Attending Physician: The law requires that the ins after death an Director: After this certificate has been signed by the light in the first of t | | Part II. Other significant condition | s contributing to death bu | ıt not resulti | ng in the underlying caus | e given in Part I. | | bacco use contribute to | the cause of death? bably 4 Unknown |
| ords, wequires is been signatured be | Completed | | | | | | | | utopsy findings available |
| COL e law r e has b | ᇍ | | | | | | autops perforr | sy prior to m <u>ed</u> ? death? | completion of cause of |
| Vital Rec ysician: The l his certificate l director, page | | 25. Was case referred to medical | 1 | | 26 Pla | ace of Death (Che | 1 Yes 2 | No 1 V | es 2 No |
| Vita lysicia this ce direct | o Re | examiner? 1 ✓ Yes 2 No | Hospital: 1 Inpatient | 2 ER/0 | Outpatient 3 DOA | Othor | | Residence 6 🗸 Othe | er: Scene |
| ing Ph After t funeral | · · I | 27. Manner of Death 1 Natural 5 Deading | 28a. Date of Injury (Month, Day Year) Nov 19, 2006 | | 10 h | njury at Work? | 28d. Describe he Victim of hou | ow injury occurred | |
| ivisior or Attend after death Director: | lä E | 2 Accident 5 Pending Investig. | ation | | | Yes 2 ✔ No | | | |
| Divis pital or A ours after leral Direc | Certification | 3 Suicide 6 Could no determine | ot be | | farm, street, factory, offic | e building, etc. | or Town, Sta | | ural Route Number, City |
| Hospital 24 hours Funeral tely fillee | | 202 Certifier | ician: To the best of my kr | | | date and place, | | · · · · · · · · · · · · · · · · · · · | |
| Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certification of the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral trictor, page 2 should be detached for use as a completely filled in the funeral Completely. | Medical | , | er:On the basis of examin | | | | | | |
| F S F O | Ž | 29b. Signature and title of certifier. | 0 | | | ense number | | 29d. Date signed (Me | |
| | | (Later to | being) | | O.0 | C.M.E. | | November 20, 2 | 006 |
| 6 | | 30 Name and address of person what Laron Locke MD. Ass | o completed ce use of d eat istant Medical Exam | , | 1 Penn Street, Ba | timore. MD 2 | 1201 | | |
| Stat | te. | 31. Date filed (Month, Day, Year) | 32. Registrar's | | A | | | | |
| Registra | | NOV 2. 8. 201 | The second secon | 15 1 | EDBALL S | | | | 1 |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 0.0 C

| | | | 1 - For State Registrar | State of Ma | iryland / De <i>C</i> | partment of F ertificate of | teaith and me <i>Death</i> | | ene 1109 | 3/552 |
|---------------------|---|----------------------|---|--|---------------------------|--|---|--------------------------------------|--|--|
| | Physici | 20 | 1. Decedent's Name (First, Middle, La | st) | 1 | | 2 | Date of Death | Day Year | 3. Time of Death |
| | /Medi | | Kobert | | LON | 1605 | | Vovem b | CR 20200 | 6 1100pm |
| | Examir | ner | 4a. Facility Name (If not institution, given | street and number) | DITAL | ^ | Location of Death | wn | Ac. County of Dea | im ore |
| | Funeral | | 5. Social Security Number 6. S | | (In yrs. last birthda | y) If Under 1 Year | If Under 24 Hrs. 9 | Date of Birth | a Bir | rthplace (State or Foreign ountry) |
| | Director | | 3/9-32-0349 | M 2□F | 78 Yrs. | Months Days | Hours Min. | (Month, Day, Y Aug 13, | 1928 Nev | v Jersey |
| | land Sw | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or | Location | | | | 10d. Inside City Limits |
| | Manyl | to | MD Ba | ltimore | Ran | dallstown | | | | 1 ☐ Yes 2√☐ No |
| | th the | Director | 10e. Street and Number | | | 10f. Zip Code | | 100 | . Citizen of What C | ountry? |
| | ath wi | rai | 5412 Old Court R | | | 2 | 21133 | | USA | |
| | items items | nue | 11. Marital Status 1 ☐ Never Married 2 ☐ Married | 12. Was Decedent E Armed Forces? | | Was Decedent of H If Yes, specify Cuba | lispanic Origin? (Specil an, Mexican, Puerto Ric | ty Yes or No- can, etc.) | 14. Race - Am Black, Whi | |
| 036 | urs af | by F | 3 ☐ Widowed 4 ☆ Divorced | 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates: | 0 | 1 ☐ Yes 2 🎇 No | Specify: | | Specify: b. | lack |
| Maryland 21215-0036 | filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23s or 28s-1 show ith, the Madical Examiliser roust by nutified at | Completed by Funeral | 15. Decedent's Ec | | 16a. De | cedent's Usual Occup | ation | 16 | b. Kind of Business | s/Industry |
| 12 | within | mpie | Elementary/Secondary (0-12) | College (1-4or 5- | -) | | during most of working | | · | |
| 2 | filed v Hygie Sther I | ပ္ပ | 17. Father's Name (First, Middle, Last) | U | | Laborer | 18. Mother's Name (F | | rcraft | |
| <u>la</u> | Aental Aental rked o | To Be | Howard Longus | | | | Minnie Hi | | , | |
| <u>a</u> | 2 should and Menis marke | Γ. | 19a. Informant's Name/Relationship (| Type, Print) | 19b. Ma | iling Address (Street | and Number or Rural F | Route Number, C | ity or Town, State, | Zip Code) |
| | and sealth m 27 | | Linwood Longus/so | n | | | ill Road Up | | | |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Depertment of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic evant, the Marical Examinet round by notified at ance. | | 20a. Method of Disposition 1 Burial 2 Cremation 3 | | cemetery, c | position (Name of rematory or other place | Date | 9 20 | c. Location - City or | Town, State |
| | permit. Page Department important: if sny injury o | | 4 ☑ Donation 5 ☐ Other (Specify 21. Signature of Euneral Service Licen | | 100 | 22. Name and Addres | ss of Facility | | | |
| B | Deperming Support | | 21. Signature of cuneral Service (Icen | Wade, Dire | | State Anato | omy Board 6 | 555 W. B | altimroe | Street |
| | | | 23a. Part Enter the disease, or company shock, or heart failure. List only | olications that caused one cause on each line | the death. Do not e | Baltimore, enter the mode of dyin | g, such as cardiac or re | espiratory arrest | , | Approximate Interval Between |
| - | Physician | | Immediate Cause (Final disease or condition | Ath | PROSC | erotic | HEART | Dise | ease | Onset and Death |
| | /Medical Examiner | | resulting in death) | | consequence of): | | | | | |
| | | ē | Sequentially list conditions, if any, leading to immediate | b. — Due to (or as a | consequence of): | | | | | |
| | cuted nd ransit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | c | | | | | | |
| ŏ | icate be executed physician and the burial-transit | | resulting in death) Last | Due to (or as a | consequence of): | | | | | |
| 68760, | tificate be executed og physician and as the burial-transit | fedical | | d | | | | | | |
| | nding p | n/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome o | f pregnancy | | | | 23d. Date of de | livery |
| . Box | death | Physician/N | in the past 12 months? 1 ☐ Yes 2 ☐ No | 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown | _ | B□Ectopic pregnancy i□ Other (specify) | | | Month | Day Year |
| J. | d by the | Phys | 9 Unknown | | | | | | | |
| ďs, | The law requires that the death cer tite has been signed by the attendir bage 2 should be detached for use | þ | Part II. Other significent conditions of | Heart | | underlying cause give | en in Part I. | | | o the cause of death? |
| င္ပ | w requ | lete | | | | | | 24a. Was an | | |
| Vital Records, | hysician: The law his certificate has E I director, page 2 s | Completed | | | | | | autopsy performe | prior to death? | utopsy findings available completion of cause of |
| <u>e</u> | | Bec | 25. Was case referred to medical examiner? | | | | 26. Place of Death (C | | No Thes | 2 No |
| <u>o</u> | Physic this co | ၉ | 1 ☐ Yes 2 No | Hospital: 1 ☐ Inpatien | A | | 4 Nursing Home | | | cify) |
| 50 | ding Phy h. After thi funeral o | Certification; | 27. Manner of Death 1 Natural 5 ☐ Pending 2 Accident investigation | 28a. Date of Injury (Month, Day | Year) 28b. Time Injury | Work | / at 28d ⟨? Yes 2 □ No | I. Describe how | njury occurred | |
| UNISION | I or Attendi after death. Director: A I in by the fu | ifica | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injur | y - At home, farm, | street, factory, office | | Location (Stree | t and Number or Ru | ural Route Number, |
| 5 | ital or A irs after rai Dire led in by | Cert | 4 Homicide | building, etc. | (Specify) | | | City or Town, S | tate) | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Medicai | 29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exem | iner: On the basis of e | examination and/or | ath occurred at the tim investigation, in my op | ne, date and place, and pinion, death occurred | due to the caus at the time, date | e(s) and manner as and place, and due | stated. to the cause(s) |
| | To the lawithin 2. To the complet | Mec | 29b. Signature and title of certifier | and manner state | 3 0. | 29c. License | | | Date signed (Monta | |
| | . ,,,, | | mary | Physic | CAN | 000 | 54558 | - INI | ovem be | R 20.2006 |
| | | | 30. Name and address of person who o | 17 | ~ | e, Print) | 4010 | , ,,, | | 2 20,2006 1021133 |
| | | • | 31. Date filed (Month, Day, Year) | 32. Registrar | 7 7 10 | Old Love | ex Kd. KA | Indalls | lown, n | 11)31135 |
| å | Sta Registr | | | nns Cosses | 's Signature | partes | | | | |

| | | 1 - For State Registrar | State of Marylar | | artment of F | | - | giene Reg. No. 20 | 06 | 37553 |
|---|-----------------|--|---|------------------|---|--------------------------------|---|--------------------------------------|--------------------------|---|
| | | Decedent's Name (First, Middle, Last | (t) | | 1 1 | | 2. Date of De | ath Day | Voor | 3. Time of Death |
| Physic | | Edward | | Ĺ | aubach | | Noveme | | Year 2006 | 14:28M |
| /Medi Exami | | 4a. Facility Name (If not institution, give | street and number) | | 4b. City, Town, o | r Location of Deat | | 4c. County | of Death | |
| | | The Johns Hopk | ins Hospita | 7 | Baltimo | XE Cit | 4 | | | |
| Funeral | | 5. Social Security Number 6. S | D., . D.E. | | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bin (Month, Da | y, Year) 3,1932 | 9. Birthpl Count | ace (State or Foreign try) |
| Director | | 210-30-3338 | 73 | Yrs. | | | Feb.28 | 3,1932 | | land |
| pu 🛦 | | Usual Residence of Decedent 10a, State 10b, County | 10c. C | ity, Town or Lo | ocation | | | | 10 | Od. Inside City Limits |
| ehol | 7 | MD Baltin | | Ess | | | | | | 1 ∐Yes 21∑ No |
| he M | Director | 10e. Street and Number | .020 | | 10f. Zip Code | | | 10g. Citizen of W | Vhat Coun | trv? |
| iled within 72 hours after deeth with the Maryland filed within 72 hours after deeth with the Maryland Hygiene. Whysiene "naturel", or Iteme 23a or 28a-f show ent, the Medical Examiner must be motified at | | 539 S. MArlyn | Avenue | | 2122 | 1 | | USA | mat occin | |
| 99th | Funeral | 11. Marital Status | 12. Was Decedent Ever in t | IS 13 | Was Decedent of H | | Specify Yes or No | | e - America | an Indian. |
| Item In | in in | 1 Never Married 2 Married | Armed Forces? 1XX Yes 2 ☐ No | , | If Yes, specify Cuba | an, Mexican, Puer | to Rican, etc.) | | k, White, e | |
| urs al | þ | 3 ☑ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | 1 ☐ Yes 2 ☐XNo | Specify: | | Specify | Whi | te |
| 2 hou | Completed | 15. Decedent's Ed | | 16a. Dece | dent's Usual Occup | ation | etrin - | 16b. Kind of Bu | siness/Ind | lustry |
| Fig. 7 | ple | (Specify only highest gra | College (1-4or 5+) | life. | DO NOT use retired | d) - | rking | Clover | land | Dairy |
| a gen di wit | NO. | 8th | , | Tr | uck Dri | ver | | | | * |
| be file tal Hy d oth | Be (| 17. Father's Name (First, Middle, Last) | | | | | | Maiden Sumam | θ) | |
| should End Ment | 2 | Christian La | ubach | | | | e Schao | | | |
| ite; Mally latter X IX INCOMES 1 and 2 should be filed within 72 hours after deeth with the Maryla 14 Heelth and Mental Hygiene. 16 the X is marked other then "naturel", or Iteme 23a or 28a-1 show other traumatic event, the Medical Examinar must be motified at | | 19a. Informant's Name/Relationship (| Type, Print) | | ng Address (Street | | | | - | |
| and and m 27 | | Cheryl Yard / | | | 0 Tupel | o Place | | | | |
| T term | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ | Description Chair | cemetery, cre- | osition (Name of matory or other place | | Date | 20c. Location - | • | |
| callulling rmit. Pages pertment of I portent: If its y injury or o | | 4 □Donation 5 □Other (Specif | 1) | | wn Ceme | | | | | |
| permit. Pages 1 an Depertment of Heel Importent: if Item 2 eny injury or other once. | | 21. Signature of Buneral Service Ucer | lus Cernelle | 6 . [] | 2. Name and Addre Connell | | | | | alto. MD 21221 |
| | | 23a. Part1. Enter the disease, or com- shock, or heart failure. List col- | plications that caused the dea | th. Do not en | ter the mode of dyir | ng, such as cardia | c or respiratory a | rrest, · | | Approximate Interval Between |
| Physician | | Immediate Cause (Final disease or condition | a Pulmona | | 4 | | | | | Onset and Death |
| /Medical | | resulting in death) | Due to (or as a conse | quence of): | 100103 | | | | | · |
| Examiner | | Sequentially list conditions, | b. Status post | Rad | ical Cy: | staprost | atecto | nV | | 7 days |
| ם כ | ner | if any, leading to immediate cause. Enter Underlying | Due to (or as a conse | quence of): | , | 1 | | / | | |
| acute ind trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c | -0 | | | | | | |
| Sien a | ũ | resulting in death) cast | Due to (or as a conse | quence of): | | | | | | |
| The Cords, F.O. box oor ou, The law requires that the death certificate be executed ste hes been signed by the attending physicien and pege 2 should be detached for use as the burial-transit | dlcal | • | d | | | | | | | |
| OX O | Me | IF FEMALE: | 23c. If yes, outcome of pregr | ancy | | | | 224 D-4 | 4 -4-15 | |
| atten for us | lan | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth 2 Fer 4 Pregnant at time of | al death 3 | ☐Ectopic pregnanc: ☐ Other (specify) _ | y | | Mor | e of delive nth | Day Year |
| S e de d | yslo | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9☐ Unknown | dea(ii 5) | Other (specify) | | | | | |
| wrequires that the death certific been signed by the attending p should be detached for use as is | by Physician/Me | Part II. Other significant conditions of | ontributing to death but not re | sulting in the u | inderlying cause giv | ven in Part I. | 23e. Did 1 | obacco use contr | ribute to th | e cause of death? |
| w requires to been signer should be | d b | Hypertensio | ^ | | | | 10 | Yes 2 No | 3 Prob | ably 4 Unknown |
| Should should | Completed | | structive Pu | M 300 m | Disease | , | 24a. Was | an 24b. V | Vere autor | psy findings available |
| he lay | Ę | | | inolat y | 2130030 | · <u>·</u> | auto perfo | ormed? | death? | psy findings available inpletion of cause of |
| VILZI licien: Ti certificete rector, pe | ပို | Bladder (25. Was case referred to medical | ancer | | | OC Place of Do | 1 ☐ Yes | | Yes | 2 No |
| sicie scent | 0 | examiner? | Hospital: 1X Inpatient 2 | ☐ ER/Outpatie | nt 3 DOA Ott | | | dence 6 □Oth | er (Specifi | d |
| P P O | 1: To | 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time o | | | | how injury occurr | | ′/ |
| of ing | t e | 1 Natural 5 Pending 2 Accident investigation | | Injury | | rk? Yes 2 □No | | | | |
| LIVISION t or Attending after deeth. Director: After din by the fune | 100 | 3 Suicide 6 Could not b | 289. Place of Injury - At | home, farm, st | reet, factory, office | | 28f. Location (City or To | Street and Numb | er or Rura | l Route Number, |
| s afte | Certification: | - CHOMINGO | building, etc. (Spec | 11 5) | | | Only of 10 | , Giate/ | | |
| To the Hospital or Attending Physicien: The lav within 24 hours after deeth. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2: | edical (| 29a. Certifier Certifying Pt (Check only one) | nysician: To the best of my kr | nowledge, deal | th occurred at the tinvestigation, in my | me, date and place | e, and due to the urred at the time, | cause(s) and ma date and place, a | nner as st and due to | ated. the cause(s) |
| o the ithin 2 o the ample | Med | 29b. Signature and title of certifier | and manner stated. | | 29c. Licens | se number | | 29d. Date signed | i (Month, | Day, Year) |
| F 3 F 8 | | 17. 7:44 | T. 1.0 | | RES. | 000 | | November | , 22 | 2006 |
| / | | 30. Name and address of person who | completed cause of death (Ite | m 23al /Tues | | -000 | | And chizel | 23 | , =000 |
| 5 | | TORIN FITTON | | | | ET BAL | TIMORE | MARYLA | ANN | |
| S | tate | | 32 Registrar's Sign | nature | , C 017C | <u>., , 0,10</u> | | | 1, | |
| Regis | | 31. Date filed (Month, Pay, Year) NOV 2 8 20 | 06 Same | KA | and I | | | | | |

06-08784

Please Type or Print in Black Indelible Ink

| ohn Michael Lu | | 1- For State | ate of Maryla | • | artment of rtificate of | | Mental | | eg. No. 200 | 6 3755 |
|--|----------------|---|--------------------------------------|------------------------|----------------------------|-----------------------------|----------------------|---|--|--|
| Physicia | | Registrar 1. Decedent's Name (First, Midd | | | | | | 2. Date of Deat | th | 3 Time of Death |
| Medical Exami | | John Michael | | - | | | | November November | | 0824 hrs |
| The second of th | | 4a Facility Name (if not institution 805 Calvin Place | | <u> </u> | | Bel Air | | | 4c. County of Dea Harford | |
| Funeral Director | | 5. Social Security Number 216-56-5794 | 6. Sex | 7. Age (In yrs. I | last birthday) Yrs | If Under 1 Year Months Days | If Under 24 Hours | | 13, 1950 c | |
| any | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Locati | on | | | | 10d. Inside City Limits |
| * * | tor | Md. Ha | rford | | | Bel Air | | Lac | Og. Citizen of What Co | 1 XYes 2 No |
| th the Maryland 23a or 28a-f sho notified at once. | al Director | 805 Calvin Pl | | | | 210 | | | U.S.A. | |
| 15-0036 filed within 72 hours after death with the Maryland I Hygiene. 14 other than "natural", or items 23a or 28a-f sh 1, the Medical Examiner must be notified at once | y Funeral | 11. Marital Status 1 Never Married 2 X M 3 Widowed 4 Div | | 2 🔀 No | | es, specify Cuban, I | | (Specify Ye s or N o- erto Rican, etc.) | White, etc. | rican Indian, Black, white |
| hours a: "natura | d by | 15. Decedent's Education (Spe | cify only highest grad | e completed) | | t's Usual Occupation | | | 16b. Kind of Business | |
| 5-0036 led within 72 h Hygiene. Other than "n | Completed | Elementary/Secondary (0-12) | College (1- | 4 or 5+) | | manager | 70 NOT use | retired) | medical | |
| 21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica | | 17. Father's Name (First, Middle | , Last) | | | 18 | | ame (First, Middle, N | • | |
| AD 2121 2 should be fi h and Mental I 27 is marked matic event, | To Be | Allan M. Lube 19a Informant's Name/Relations | r hip (Type, Print) | | 19b. Mailing | Address (Street | | ret Mulle or Rural Route Num | en ber, City or Town, Stat | e, Zip Code) |
| MD 12 shc th and 27 is umati | | Charmaine Lub | er/wife | | 805 (| Calvin Pl | ace, E | sel Air, N | /d. 21014 | |
| Baltimore, M permit Pages I and 2 Department of Health Important: If item 2 injury or other traun | | 20a. Method of Disposition | n 3 Removal fro | m State | crematory or oth | | · 1 | Date | 20c. Location - City o | |
| timent trant: | | 4 Donation 5 Other 8 | ōecify: | Ва | | Crematory | | ./24/06 | Baltimore | |
| Balt permit Depart Impor injury | | 21. Signature of Eureral Service | 6- | | 1 | | | | Bel Air, | Inc. |
| Physician /Medical | | 23a Part I. Enter the disease, of failure. List only one cause | on each line. | | | | | | est, shock, or heart | Approximate Interval Between Onset and Death |
| xaminer | 1 | Immediate Cause (Final disease or condition resulting in death) | Due to (or as a | | | focal myoc | arman | IIDFOSIS | | Beauti |
| | <u>_</u> | Sequentially list conditions, if any, leading to immediate | b. Due to (or as a | consequence | of): | | | | | |
| | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated | С | | | | | | | |
| ecuted and transit | | events resulting in death) Last | Due to (or as a d. | consequence o | ot): | | | | | |
| ਭੂਬ ਫ | edical | Xunpended | AMENDED | #23a.27. | nerME G86 | 2, 12/21/06 | . TT | | | |
| | | IF FEMALE: 23b. Was decedent pregnant in the | 20 | utcome of preg | nancy | | | | 23d. Date of deliver | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri | Physician/M | past 12 months? | I I Live bi | ant at time of de | ooth _ | al death 3 ner (Specify) | Ectopic pre | gnancy | Month | Day Year |
| P.O. BO: | اھ | Part II. Other significant condit | ions contributing to | death but not r | esulting in the u | nderlying cause giv | en in Part I. | | bacco use contribute to | |
| ords, P.C w requires that as been signed be should be deta | leted | | | | | | | 24a. Was a | | utopsy findings available completion of cause of |
| Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death all Director: After this certificate has been signed by led in by the flueral director, page 2 should be deach | Completed | | | | | | | perform 1 V Yes 2 | med? death? | |
| Vital F hysician: this certifi I director, | o Be | 25. Was case referred to medica examiner? 1 ✓ Yes 2 No | Hospital: | patient 2 | ER/Outpatient | | f Death (Che | | Residence 6 🗸 Othe | r: Scene |
| ion of \ tending Phy eath for: After the | -1 | 27. Manner of Death | 28a. Date of (Month, | of Injury Day,Year) | 28b. Time of Ir | njury 28c. Injury | at Work? | | ow injury occurred | |
| ivision or Attendi after death Director: | atio | 1 X Natural 5 Pend 2 Accident Inve | ding stigation | | | | s 2 No | | | |
| Division Hospital or Attent 24 hours after death Funeral Director: tely filled in by the | Certification: | 4 Homicide dete | ld not be 28e. Place (Specify) | of Injury - At h | ome, farm, stree | t, factory, office bui | lding, etc. | 28f. Location (S or Town, St | | ural Route Number, City |
| To the Hos within 24 h To the Fun completely | Medical (| | | f examination a | | | | | e(s) and manner as star and place, and due to the | |
| FSFS | M | 29b. Signature and title of certific | | | | 29c. License | | | 29d. Date signed (Mo | |
| | | largone of | re Mull | | | O.C.M | .E. | | November 19, 2 | 006 |
| | | Name and address of person Margarita Korell MD. | who completed cause Assistant Med | , | | enn Street, Bal | timore, M | D 21201 | | |
| St | ate | 31. Date filed (Month, Day, Year) | 32. Xe | gistrar's Signat | | B) | | | | |

| | | For State Registrar | State of | Marylan | | rtment o | | | | Reg. No. | 06 | 37555 |
|---|---------------------|--|---|--|--|---|------------------------------|---|--|---------------------------------|---|---|
| Physicia | | 1. Decedent's Name (First, Middle, Last) Frances G. Le | eilich | | | | | No | 2. Date of De Month vember | Day | Year 06 | 3. Time of Death 9.50 A M |
| /Medic Examin | | 4a. Facility Name (If not institution, give : Genesis Health Car | | | enter | 4b. City, To | | cation of Death | | | ty of Death | re |
| Funeral Director | | Social Security Number 6. September 6. | | | last birthday) Yrs. | If Under 1 Months D | | Under 24 Hrs. Hours Min. | 8. Date of Bin (Month, Da 2-11-19 | h y, Year) | 9. Birthp Coun | place (State or Foreign htry) |
| | | Usual Residence of Decedent 10a. State 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | | | IOd. Inside City Limits 1 ☐ Yes 2 ☑ No |
| ith the Ma or 28a-f | Director | MD Baltimore 10e. Street and Number | | | Balt | 10f. Zip Co | | <u> </u> | and the second second | 10g. Citizen o | What Cour | |
| Lat y identify Z 1 Z 1 D-0000 2 should be filed within 72 hours after death with the Maryland and Mentally typique. Is marked other then "natural", or itema 23a or 28a-f show aumatic event, the Modical Examirer must be notilized at | by Funeral Director | 6120 A11wood Cours 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced | 12, Was Decedi Armed Forc 1 ☐ Yes 2 If Yes, Give Year or Dati | es? [] tNo | " | Vas Deceden Yes, specify | t of Hispa Cuban, I | anic Origin? (Sp Mexican, Puerto Specify: | ecity Yes or No Rican, etc.) | | ace - Americ ack, White, ify: Whi | etc. |
| within 72 hou liene rithen "natura | Completed | (Specify only highest grad | cation | | (Give | ent's Usual C kind of work of DO NOT use Cal sec | done duri retired) | ng most of work | ing | 16b. Kind of | | dustry |
| permit. Pages 1 and 2 should be filed within permit. Pages 1 and 2 should be filed within Department of Health and Mohall Hygiene. Important: if item 27 is marked other then any injury or other traumatic event, the Manne | To Be C | 17. Father's Name (First, Middle, Last) Albert M. Greenf | ield | | | | 18 | Mother's Nam Mary M | e (First, Middle, iles | Maiden Suma | ıme) | |
| nd 2 shou nd 2 shou alth and M 27 ia mar r traumat | | 19a. Informant's Name/Relationship (Ty Mary G. Hutchin | | ster | | • | | | al Route Numbe imonium | | | (Code) |
| mit. Pages 1 a partment of Her partment of Her portant: if item y injury or othe | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) | emoval from St | ate C | Place of Disponentery, crentool | natory or othe | r place) | 1 | Date 27/06 | 20c. Location | | |
| permit. Departm Importa any inju | | 21. Signature of Funeral Service Licens | L | 0.5 | 22 | . Name and | Address | of Facility Lor | ing Bye | rs Fun | eral I | Directors,In |
| Physician /Medical Examiner bhysician and physician and stree physician and stree physician and street physician | dical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or | as a consequence as a c | uenss of). | errhy | 74 B | ma | • | | | Onset and Death |
| The Cordins, F.O. BOX 00 The law requires that the death certificat sie hes been signed by the attending phypage 2 should be detached for use as the | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | | h 2 ∏ Feta ntattime of d | ıl death 3 [| Ectopic preg | | | | | Date of deliver | ery Day Year |
| w requires that it been signed by should be deta | ρ | Part II. Other significant conditions con Demention | ntributing to dea | th but not res | ulting in the ur | nderlying cau | se given i | in Part I. | 23e. Did t | | | he cause of death? |
| | Completed | | | | | | | | 24a. Was autoj perfo 1 ☐ Yes | an 24b osy ormed? 2 No | b. Were auto prior to co- death? 1 \(\text{Yes} | opsy findings available impletion of cause of |
| SION OI VIIAI I tending Physician: The leath. tor: Atler this certificate the funeral director, pag | ation: To Be | 25. Was case referred to medical examiner? 1 | lospital: 1 In In | | ER/Outpatien 28b. Time of Injury | | Other: Injury at Work? | 4 Jursing He | th <i>(Check only o</i> ome 5 ☐ Resi 28d. Describe | dence 6 □O | | У) |
| To the Hospital or Attending within 24 hours slier death. To the Funeral Director: Alian completely filled in by the fune. | Certification: | 3 Suicide 4 Homicide 6 Could not be determined | 28e. Place of building | f Injury - At h , etc. (Special | ome, farm, str | eet, factory, o | office | | 28f. Location (City or To | | nber or Rura | al Route Number, |
| To the Hospital or At within 24 hours after or To the Funeral Direc completely filled in by | ledical (| 29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami | | is of examina | | | | | | | | |
| To the within To the comp | W | 29b. Signature and title of certifier | GAO | m | 7 | | icense n | | - | Vovem! | | |
| 7 | | 30. Name and address of person who co | | | п 23а) (Туре, | Cha. | les | SF | Touse | n Ni | 021 | 1204 |
| Sta Registr | | 31. Date filed (Month, Day, Year) NOV 2 8 201 | 32, Re | gistrar's Sign | ature Apr | whi. | | | | | | |

| | | | State of Maryland / Department of Health and Me | - | _ | |
|---------------------|--|----------------|--|--|--|--|
| | | | 1 - State Contificate of Dooth | | /IIIIh | 37556 |
| | | | 1103101.0 | 2. Date of Death | J. Nő: | 3. Time of Death |
| | Physicia | | | Month November 1 | Day 2006 | 7:00 P M |
| | /Medic Examin | | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death | | 4c. County of Death | |
| 100 | 7. | | National Lutheran Home Rockville | | Montgomer | |
| | Funeral | | 5. Social Security Number 6. Sex 198-24-9892 1 🖾 M 2 🗆 F 7 3 Yrs. If Under 1 Year If Under 24 Hrs. I | B. Date of Birth (Month, Day,) January 12 | (ear) 9. Birthp | lace (State or Foreign try) |
| Γ. | Director | | 198-24-9892 Taylor 73 Yrs. | January 12 | 2, 1933 Penns | sylvania |
| | yland how | | 10a. State 10b. County 10c. City, Town or Location | | 1 | Od. Inside City Limits |
| | sa-1 s | Director | Maryland Montgomery Rockville | | | 1X Yes 2 □ No |
| | with th | Dire | 10e. Street and Number 10f. Zip Code | 109 | g. Citizen of What Cour | try? |
| | eath v | Funeral | 609 Goldsborough Drive 20850 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec | | United Stat | |
| (0 | or iten | | Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ri | ican, etc.) | Black, White, | etc. |
| 903 | be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Neultral Exart act must be notified at | d by | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1959 1 ☐ Yes 2 ☒ No Specify: | | Specify: Wh | ite |
| 5-0 | "natu | Completed | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | g 16 | Sb. Kind of Business/Ind | lustry |
| 12 | withir ene. than | ошо | Elementary/Secondary (0-12) College (1-4or 5+) 4 Government Relations Director | | Government Re | lations |
| d 2 | e filed within al Hygiene. I other then " vent, I'r Me | Be Co | 17. Father's Name (First, Middle, Last) 18. Mother's Name (| 1 | | |
| lar | Mental arked o | To B | Andrew Burke Lampe Rose Qua | i1 | | |
| Maryland 21215-0036 | 2 should be and Mental is marked of aumatic ev | | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural) | | | |
| | ges 1 and 2 should it of Health and Men if item 27 is marke or other traumatic | | Mona M. Lampe/Wife 609 Goldsborough Drive, 20a. Method of Disposition 20b. Place of Disposition (Name of Da | | Lie, Maryla Oc. Location - City or To | |
| nor | ages nt of I t: If its / or o | | 1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State cemetery, crematory or other place) Novemb | er 24. | Bethesda, 1 | |
| Baltimore, | permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar once. | i | | | | |
| ä | Depared Depared Important in sany ire | | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funer 300 W. Montgomery Avenue | al Home, Rockvil | Rockville, Ir le, Maryland | 20850 |
| П | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause of each line. | respiratory arres | t, | Approximate Interval Between |
| | Pnysician | | Immediate Cause (Final disease or condition | | | Onset and Death |
| | /Medical Examiner | | resulting in death) Due to (or as a consequence of): | | | |
| | 4. | er | Sequentially list conditions, if any, reading to immediate b. Corres are a term of 1 Sec. Due to (or as a sonsequence of): | 5.4 | 10 | years_ |
| / | uted d ansit | Examiner | Cause (Disease or injury that initiated events Cause (Disease or injury that initiated events | | 1 | 5 years |
| , | ate be executed nysician and he burial-transit | | resulting in death) Last Due to (or as a consequence of): | | | |
| 68760, | cate by physic s the bi | dical | d | | - | |
| 9 X | The law requires that the death certificat ite has been signed by the attending phy age 2 should be detached for use as th | Physician/Medi | IF FEMALE: 23c. If yes, outcome of pregnancy | | 23d. Date of delive | rv. |
| Вох | death a atter d for u | iciar | 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) | | Month | Day Year |
| P.0 | that the death led by the atter detached for u | hys | 9 Unknown 9 Unknown | | | |
| | res tha signed be det | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | cco use contribute to th | |
| ord | w require been sig should b | eted | Le reprovoscular disease | 4 | | ably 4 □Unknown |
| Vital Records, | e law has b | ompleted by | CELEPLOYUSCOLOL of 186016 | 24a. Was an autopsy performe | prior to cor | osy findings available inpletion of cause of |
| la | | e Co | 25. Was case referred to medical 26. Place of Death / | 1 Yes 2) | No 1 ☐ Yes | 2 🗆 No |
| Z | | OB | examiner? | | ce 6 ☐Other (Specify | ') |
| n of | ng Phys ter this neral di | J: UC | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28 Work? 28d. Natural 5 ☐ Pending (Month, Day Year) Injury Work? | 3d. Describe how | injury occurred | |
| sio | tandii leath. Ior: A the fu | catle | 2 Accident investigation M 1 Yes 2 No | Pr. 1 1' 1'01 - | | 10 |
| Division | or At after of Diraci in by | Certification: | 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | City or Town, | et and Number or Rura State) | I Houle Number, |
| _ | To the Hospital or Attanding Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors. | a C | 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an | nd due to the cau | se(s) and manner as st | ated. |
| | n 24 h | edical | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. | d at the time, dat | e and place, and due to | the cause(s) |
| L | To the to the complete to the total complete | Σ | 29b. Signature and title of certifier 29c. License number | | d. Date signed (Month, | • |
| • | _ 1 | | Same & Maller Mp D0550612 | 1 | lovem ber | 20,2006 |
| | 15+1 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel G. Maller, M.D. 9701 Veirs Drive, Rockville, M. | farvland | 20850 | |
| 243 | Sta | te | Samuel G. Maller, M.D. 9701 Veirs Drive, Rockville, M. 31. Date filed (Month, Day, Year) NOV 2 8 2006 32. Registrar's Signature | -ar y rand | | |
| 5. | Registi | | NOV 2 8 ZUUG | | | |

| | | í | 1 - For State Registrar | State of M | arylar | | artment rtificate | | | ınd M | - | giene Reg. No. | 06 | 3755 | 7 |
|---|---|------------------|--|---|-----------------------------------|------------------------|------------------------------------|--------------------|---------------------------|----------------------|---------------------------------------|--------------------------|---------------------------|--|-----------|
| | Dhyoisi | | 1. Decedent's Name (First, Middle, Last) | | | | | | | | 2. Date of De Month | ath Day | Year | 3. Time of Death | 1 |
| | Physici /Medio | | Ester May Lambert | | | | | | | | 11 - | 17 - | 06 | 1842 | М |
| | Examin | er | 4a. Facility Name (If not institution, give: | Mada. | 10 | 101 | 4b. City, | | Location o | | | | ty of Death | | |
| | Funeral | | 5. Social Security Number 6. Sec | | ge (In yrs. | last birthday) | If Under | 1 Year | If Under 2 | 24 Hrs. | 8. Date of Bir | th | 9. Birth | place (State or Fore | eign |
| | Director | | 230-30-3343 |]M 2∰F | 83 | Yrs. | Months | Days | Hours | Min. | Mar. 1 | 9 , 1923 | 3 Nort | h Carolir | na |
| | and | | Usual Residence of Decedent 10a. State 10b. County | | 10c. Cit | ty, Town or Lo | cation | | | | | | | 10d. Inside City Lim | its |
| | Maryi | ţ | Maryland Wicomic | 0 | Sal | isbury | | | | | | | | 1 ☐ Yes 21X | No |
| | th the | lrec | 10e. Street and Number | | | | 10f. Zip | Code | | | | 10g. Citizen o | of What Cou | intry? | |
| | ath wi | Funeral Director | 1110 Tyler Avenue | | | | 21 | 804 | | | | USA | | | |
| | ltems freern | nue | 11. Marital Status 1 ☐ Never Married 2 ☐ Married | Was Decedent Armed Forces 1 ☐ Yes 2X | ? | .S. 13. | Was Deced If Yes, spec | ent of Hi | spanic Orig n, Mexican | gin? (Sp , Puerto | ecify Yes or No Rican, etc.) | 14. R | ace - Amer lack, White | ican Indian, , etc. | |
| 920 | of, or | ٥ | 3X Widowed 4 Divorced | If Yes, Give Year or Dates: | | | 1 ☐ Yes 2 | ₹ No | Specify: | | | Spec | city: Wh | nite | |
| 21215-0036 | within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f ehow I.a Medical Examirer must be notified at | Completed | 15. Decedent's Edu (Specify only highest grad | cation e completed) | | (Give | dent's Usua kind of wor | k done d | uring most | of work | ing | 16b. Kind of | Business/I | ndustry | |
| 121 | within ene. then | mp | Elementary/Secondary (0-12) | College (1-4or | 5+) | | <i>DO NOT</i> us omema l | | | | | | own Ho | nme | |
| d 2 | Hygie other ent, II | Be Co | 17. Father's Name (First, Middle, Last) | | | | Onchio | ICI | 18. Mothe | r's Name | e (First, Middle, | | | AIC | |
| ılan | uld be Jental rked itc ev | To B | Arthur (nmn) Shee | ts | | | | | C | a11: | ie (nmn |) Roark | | | |
| Maryland | 2 sho and I is ma | | 19a. Informant's Name/Relationship (Ty | рө, Print) | | 19b. Mailir | ng Address | (Street a | | | al Route Numbe | | | ip Code) | |
| e, r | 1 and Health em 27 ther t | | Mary Wallen/ Daugh 20a. Method of Disposition | ter | 20b. F | 1110 Place of Dispo | | | e., S | | bury, I | MD 2180 20c. Location | | own State | |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or items 23s or 28e-f ehow appringury or other treumatic event, the Micdical Examination matches notified at ADGE. | N N | 1 ⊠Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) | emoval from State | | cemetery, crei | matory or ot | her place | . ! | | 22.25 | | | | |
| altir | mit. Pertm. | | 21. Signature of Funeral Servica Licens | 90 | 1 St | . Geor | GE S | d ddres | s of Facility | LIC | me, P. | Perryn | an, r | aryland_ | _ |
| <u> </u> | Depermine Impo | | Hand Sty | | | 1 | 317 C | is ru lokes | bury | Rd. | , Abing | don, Ma | aryla | nd 21009 | |
| н | | | 23a. Part1. Enter the disease, or compl shock, or heart failure. List only or | cations that cause ne cause on each l | d the deat ine. | th. Do not ent | er the mode | of dying | , such as | cardiac | or respiratory a | rrest, | | Approximate Interval Between Onset and Death | |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | Myo | CAYOU | 4C 11 | PARTI | ON | | | | | | | |
| | Examiner | | ſ | Due to (or as | a conseq | juence or). | | | | | | | | | |
| | 70 ≃ | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as | a nurreud | јизнев जी: | | | | | | | | | |
| | and and i-trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as | a consen | mence of). | | | | | | | _ | | |
| 8760, | cate be executed physicien and the burial-transit | dicai E | L, | 1 | | | | | | | | | | | |
| 9 | death certificate be executed e ettending physicien and nd for use as the burral-transit | Medic | ISSENIE . | | | | | | | | | | | | |
| Вох | death certific ettending pl | lan/N | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 3c. If yes, outcome 1 ☐ Live birth | 2 Feta | aldeath 3□ | Ectopic pre | | | | | | Date of delivery | ery Day Year | |
| o. | that the dealed by the e | ysic | 1 Yes 2 No 9 Unknown | 4□Pregnant a 9□ Unknown | t time of c | leath 5 | Other (spe | ecity) | | | | | | July 1 July 1 | |
| ₽. | requires that the een signed by th nould be detache | by Physician/Me | Part II. Other significant conditions con | tributing to death I | out not res | sulting in the u | nderlying ca | ause give | n in Part I. | | 23e. Did t | obacco use co | ntribute to | the cause of death? | |
| rds | w requires that s been signed b should be det | ed b | chronic renal fair | we | | | | | | | 10 | Yes 2 No | 3 ☐ Pro | bably 4 □Unknov | wn |
| ecc | a γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ γ | Completed | cardiomyopakhy | | | | | | | | 24a. Was autop | osy | prior to o | opsy findings availal ompletion of cause o | ble of |
| 田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田 | Page 1 | | | | | | | | | | | rmed? 2 3 No | death? | 2□ No | |
| Ζ | Physician: this certifice ral director, p | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ ₩6 | lospital: | ont 2 | ER/Outpatier | nt 3□ DO. | Othe | ~ | | n <i>Check only o</i> me 5 ☐ Resid | | lebas (Casa | A.1 | - |
| 0 | ig Phy ter this neral d | n: To | 27. Manner of Death | 28a. Date of Inj | ury | 28b. Time of | | Bc. Injury Work | | | 28d. Describe | | | <u>''y)</u> | |
| sior | Attending or death. sctor: After by the funer | atio | 1 | (171011111) | ., | injury | М | | es 2 □ N | | | | | | |
| Division of Vital Records | or Att | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of In building, e | jury - At h tc. <i>(Specil</i> | ome, farm, str fy) | reet, factory, | , office | | | 28f. Location (S City or Tox | | nber or Rui | al Route Number, | |
| - | To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Dirsctor: After th completely filled in by the funeral | | 29a. Certifier 1 Certifying Phys | sician: To the best | of my kno | owledge, deatl | h occurred a | at the tim | e, date and | d place, | and due to the | cause(s) and r | nanner as | stated. | |
| | n 24 h | edical | (Check only 2 Medical Exami | ner: On the basis of and manner s | of examina tated. | ation and/or in | vestigation, | in my op | inion, deat | h occurr | ed at the time, | date and place | e, and due | to the cause(s) | |
| | To the vithin To the comple | Σ | 29b. Signature and title of certifier | | | | 29c. | License | number | 20 | | 29d. Date sign | ned (Month | Day, Year) | |
| • | 1 | | 1 / | | N | 0 | | 1/3 | 409 | 3 | | 11-20- | -06 | | |
| | 4 | | 4 4/ | mpleted cause of | death (Iter ROII | n 23a) (Туре, | Print) | Ishi | IN N | 10 | 21801 | | | | |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32 Regist | rar's Signa | ature A | 048 2 | J-14 | 7 | | | | | | |
| | Registr | ar | MOV 9 8 200 | 16 12 32 | Part of | S. John | Service Services | | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

| | | 1- For State Registrar | | (| Certificate | e of | Death | | | F | teg No | ZU | UD | J | 100 |
|--|---------------|--|---|-------------------------|-------------------|------------|--------------------------------------|--------------------|--------------|-------------------------|--------------|------------------|----------------------------|--------------|---------------------------|
| // Physicia | ın/ | 1. Oecedent's Name (First, Midd | lle,Last) | | | | | | 2 | 2. Oate of Dea Month | ath Oay | Year | 1 | 3. Time of D | |
| ledical Examir | ner | Gordon Alan M | | | | | | | | Novembe | r 8, 2006 | leal | | 2232 h | ırs |
| | | 4a. Facility Name (if not instituted 5303 Carlton St. | on, give street and nu | umber) | | 4 | b. City, Town, o Bethesda | or Location | of Oeath | | | unty of itgom | | | _ |
| Funeral Director | | 5. Social Security Number unk | 6. Sex | 7. Age (In) | yrs. last birthda | y) Yrs. | If Under 1 Ye Months Da | | der 24Hrs. | 8. Date of B | | | 9 Birth Foreign Cour | | ^{e or} unk |
| | ŀ | Usual Residence of Decedent | 1 2 1 | 50 | | 113. | LL | | | pury r | 1, 17. | 00 | | | |
| any | ŀ | 10a State 10b. County | | 10c. | City, Town or I | ocatio | on | | - | | | | | 0d Inside | City Limits |
| * . | L | MD Mon | tgomery | , | Bethesd | a | | | | | | | | 1 Yes | 2 X No |
| Aaryland 28a-f show 1 at once, | 용 | 10e. Street and Number | regomery | | beenesa | | 10f. Zip Code | | | | 10g Citizen | of Wha | t Count | γ? | 1 |
| more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. aut: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once | I Director | 5303 Carlton | | | | | 20816 | | | | | | | | unk |
| ath wit | Funeral | 11. Marital Status unk 1 Never Married 2 M | larried Armed F | orces? u | nk | | Oecedent of Hes, specify Cuba | | | | | Race - White, | | an Indian, E | slack, |
| fter de | | 3 Widowed 4 Oi | 1 Yes vorced If Yes, Give Yes | 2 N ar | No | 1 | Yes 2X N | o specify | r. | | Spe | cify Ta | hite | 2 | |
| ours a stura | d by | 15. Oecedent's Education (Spe | l or Dates: ecify only highest gra | de complete | d) 16a. Dec | edent | 's Usual Occupa | ation (Give | kind of wo | ork done | 16b. Kind | | | | _ |
| 5 72 hou in "nat | leted | Elementary/Secondary (0-12) | College (| 1-4 or 5+) | dur | ng mo | st of working lif | e. DO NO | T use retire | ^{d)} unk | | | | | unk |
| 5-0036 Iled within 72 Hygiene. I other than the Medical | Comple | unk | unk | | | | | | | | | | | | |
| filed v filed v I Hygi ed oth | ပို | 17. Father's Name (First, Middle | , Last) | | | | unk | 18. Mothe | er's Name (| First, Middle, | Maiden Suri | name) | | u | nk |
| ID 21215-003 should be filed within and Mental Hygiene. This marked other the natic event, the Mediation. | Ö | 19a. Informant's Name/Relations | ship (Type, Print) | | 19b. M | lailing | Address (Stre | eet and Nu | mber or Ru | ıral Route Nu | mber. City o | r Town | State 2 | 7in Code) | |
| and 2 shoulealth and 1 tem 27 is traumatic | Ti | O.C.M.E. | | | | | enn Str | | | | | | | | |
| nore, MD ages I and 2 sh nnt of Health an nt: If item 27 i | | 20a. Method of Disposition | | | | isposi | tion (Name of c | | | Date | | | lity or To | own, State | |
| Pages ent of | | 1 Burial 2 Cremation 4 Donation 5 4 Other S | n 3 Removalfi rec <i>ify:</i> in | | Crematory | 01 0111 | er place) | | | | | | | | |
| Baltimore, permit. Pages I ar Department of Hee Important: If ite | ı | 21. Signature of Funcial Service Ronald | Licensee | Direc | tor I | 22. No | ame and Addres | ss of Facili | ty Door 1 | 6 E E T | 7 D - 1 | | | 0.4 | |
| | _ | 11mm/ | 14 mui | | 1 | | ame and Addres ate Ana Ltimore | | | | | | | Stree | ! T |
| Physician /Medical | | 23a. Part. Enter the disease, or failure. List only one cause | r/complications that one on each line. | aused the d | eath. Do not e | nter th | e mode of dying | g, such as | cardiac or i | respiratory ar | rest, shock, | or hear | í | Between | ote Interval Onset and |
| xaminer | Ì | Immediate Cause (Final disease or condition resulting in death) | a Asphyxi Due to (or as a | | | y zo | olpidem i | ntoxic | ation | | | | -1 | De | eath |
| | | | b. | a consequer | ice or). | | | | | | | | | | |
| | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | Due to (or as a | a consequer | nce of): | | | | | | | | | | |
| | Examiner | (Disease or injury that initiated events resulting in death) Last | C. Due to (or as a | a consequer | nce of): | - | | | | | | | = | | |
| ecuted and - transit | | | d | | | | | | _ | | | | | | |
| 6 be exe ysician a burial - | n/Medical | X UNPENDED | AMENDED | #23a,27 | .28a-f. | perl | Æ, g861, | 11/30 |)/06 TI | 1 | | | | | |
| 8760, tificate be ex ng physician as the burial. | § | IF FEMALE: 23b. Was decedent pregnant in t | 23c. If yes, | outcome of | pregnancy | 1 | 7 07 | | , | | 23d Da | ate of de | elivery | | |
| 68 certifi | iai | past 12 months? | Live | oirth nant at time | of death | - | | Ectop | ic pregnan | су | Mor | nth | Da | у | Year |
| Box 687 he death certific the attending p | ysicia | 1 Yes 2 No 9 Un | iknown 9 Unkn | | or death 5 | Oth | er (Specify) | | | | | | | | |
| trhe by th | Phy | Part II. Other significant condi | tions contributing t | o death but | not resulting in | the ur | nderlying cause | given in F | art I. | 23e. Oid t | obacco use | contribu | ute to th | e cause of | death? |
| P.O. rres that the signed by | d by | | | | | | | | | 1Ye | s 2 No | 3 | Probat | bly 4 🗸 | Unknown |
| of Vital Records, ing Physician: The law require there this certificate has been simeral director, page 2 should b | ompleted | | | | | | | | | 24a. Was | | | | | s available |
| e law | d m | | | | | | | | | | rmed? | dea | ath? | npletion of | |
| tal Rection: The certificate ector, page | O | 25. Was case referred to medical | al T | | | | 26 Plan | e of Death | (Check or | 1 Yes | 2 No | 1 | / Yes | 2 | No |
| /ita | Be | examiner? | Hospital: | Inpatient 2 | 2 ER/Outp | atient | | Other ₄ | | | Residence | 6 1 | Other: 9 | | |
| n of V ing Phy After th | <u>٩</u> | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Date | of Injury | 28b. Tim | | | ury at Wor | _ • | | | | | | |
| on on arth. | Ę | | ding End 1 | h, Day,Year) 1/8/200 | 6 End | 10.1 | 26 pm 1 | Yes 2 | | ed Describe | | | | bag ov | rer head |
| Division tal or Attendi rs after death. al Director: A | liga | | 28e Plac | | | | t, factory, office | | a | nd inger | | | | Route Nu | mber, City |
| Divi | ertification: | A Odicido | ald not be ermined (Specify) | resid | once | | | _ | | or Town, 303 Car | State) | | | | |
| Hosp 24 hou Fune tely fi | ပ | 20a Certifier | hysician: To the be | | | occurr | red at the time, of | date and p | | | | | | | 11110 |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | Medical | one) 2 Medical Exa | aminer:On the basis and manner: | of examinati | ion and/or inve | stigati | on, in my opinic | on, death o | ccurred at | the time, date | and place, | and due | to the | cause(s) | |
| 0 11/2 11/2 | ž | 29b. Signature and title of certifi | | 2110 | | | | ise numbe | r | | 29d Date | signed | (Month | n, Day, Year | r) |
| | | Forshe. | self | MM) | | | 0.0 | M.E. | | | Novem | ber 9 | , 2006 | | |
| | | 30 Name and address of person | (/ | | | 111. | Done Of | Dalit's | ore tro | 04004 | • | | | | |
| | | Tasha Greenberg MD 31 Oate filed (Month, Day, Year) | | egistrar's Sig | | 1111 | Penn Street | , Baitim | ore, MD | | | | | | |
| St Regist | ate rar | NOTE THE (Month, Day, Year) | 40 | -giad a i 5 01(| | 100 | and the same | | | | | | | | |

| | | | For State | State of Mary | | | | | Mental Hy | giene | 07550 |
|---------------|--|-------------------|---|---|-----------------|--|-------------------------|----------------------------------|---|------------------------------|-------------------------------------|
| | | | State Registrar | | | Certifica | te of De | eatn | | Rag. Ne UUC | 3/333 |
| | Physicia | an | Decedent's Name (First, Middle, Last) | | | ٨ | Λ). | | 2. Date of De | Day Yea | 3. Time of Death |
| | /Medic | | Kicharol | Eols | 50N | 11 03 | 1010 |) / | Nov | 1/200 | 6 00 15 |
| Į. | Examin | er | 4a. Facility Name (If not institution, give | street and number) | 10- | 1 / |) lown, or Lo | ocation of Deat | n | 4c. County of De | oatn — |
| | | | 5. Social Security Number 6. Sec | HOSPITZ | yrs. last birth | Ter (| r 1 Year If | f Under 24 Hrs | 8. Date of Bir | * Rent | irthplace (State or Foreign |
| | Funeral Director | | | §M 2□ F 84 | | rs. Months | | Hours Min. | | y, Year) 1922 | Country) OH |
| | | İ | Usual Residence of Decedent | 04 | | | | | TED 24 | , 1)22 | J11 |
| | yland | | 10a. State 10b. County | 10 | c. City, Town | or Location | - | - | | | 10d. Inside City Limits |
| | Mar Hed | į | MD Kent | C | hester | town | | | | | 1 ☐ Yes 2X No |
| | r 288 | Director | 10e. Street and Number | | | 10f. Zi | p Code | | | 10g. Citizen of What | Country? |
| | h wit | | 810 South Meadowvi | ew Drive | | 2 | 1620 | | | USA | |
| | dea | Funerai | 11. Marital Status | 12. Was Decedent Ever Armed Forces? | in U.S. | 13. Was Dece | edent of Hispa | anic Origin? (S Mexican, Puer | Specify Yes or No | - 14 Race - Ar Black, W | merican Indian, |
| 9 | or it | | 1 ☑ Never Married 2 ☐ Married | 1 ☐ Yes 2 🖾 No | | 1 ☐ Yes | | Specify: | , | Specify: | mo, oto. |
| 5-0036 | within 72 hours after death with the Maryland ene. than "natural" or teme 23a or 28a-f ehow the Medical Examiner must be motified at | d by | 3 Widowed 4 Divorced | If Yes, Give Year or Dates: | | | | | | 1 | white |
| Ϋ́ | "nati | Completed | 15. Decedent's Edu (Specify only highest grad | | | Decedent's Usi Give kind of w | ork done duri | on ing most of wo | rking | 16b. Kind of Busines | ss/Industry |
| 2 | han han | E E | Elementary/Secondary (0·12) | College (1-4or 5+) | | iife. DO NOT or/wri | | | | 07 + 07 + 0 + 0 + 7 | |
| 2 | filed v Hygie other t | | 17. Father's Name (First, Middle, Last) | | act | OF/WEI | | Mother's Na | me (First Middle | entertain: Maiden Sumame) | nent |
| ä | d of other | Be | | | | | | Goldie | | walden Samane) | |
| Maryland 2121 | permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. I important: if fiem 27 is marked other than "natural", or iteme 23a or 28a-f show eny injury or other treumatic event, the Medical Examinar must be multiled at once, | ၉ | Edward A. Maloy 19a. Informant's Name/Relationship (Ty | una Print | 10h | Mailing Addros | | | | er, City or Town, State | Zin Codo) |
| a N | hand hand 7 is r | | Tucker Bobst/son | pe, riini) | | | | | | nestertown, | |
| e, | 1 and Healt Healt ther | | 20a. Method of Disposition | 12 | | Disposition (Na | | JWVIEW | Date Date | 20c. Location - City | |
| altimore, | ages or o | | 1 Burial 2 Cremation 3 F | Removal from State | cemetery | , crematory or | other place) | | | 200. 2002.1011 | or rown, orang |
| ≣ | rtmer rtant rtant | | 4 ☑Donation 5 ☐Other (Specify) 21. Signa on a Funeral Service Licens | £ + 1 | | 00 Name | and Address of | of English | | | |
| Ba | Depa mpo my in | | Pon 11d S. | | tegr _ | State | | my Boar | | . Baltimor | e Street |
| | | | 23a. Part . Enter the disease or compl | // July | doath Don | | | MD 2120 | | rroct | Approximate |
| | | | shock, or heart failure. List only of | ne cause on each line. | GBAIN. DO IN | or or to the the | de or dying, s | sucii as cardia | O O Tespitatory a | trest, | Interval Between Onset and Death |
|) | Physician | | disease or condition resulting in death) | . aden | ocaro | mon | na o | A CC | ton | with | |
| | /Medical Examiner | | 1 | Due to (or as a co | insequence o | f): | pt ; | De | , | | 3 month |
| | | - | Sequentially list conditions, | b. Due to (or as a co | nsequence of | 70 / | P | gune | | | 0 |
| | led Isit | nin | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | C / / | | .,. | , | | | | Hears |
| | and and | Examiner | that initiated events resulting in death) Last | c. Due to (or as a co | nsequence of | f): | | | | | 1 |
| 8760, | The law requires thet the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | | | _ | | | | | | | |
| 687 | ficate phys s the | Physician/Medical | | J | | | | | | | |
| Box (| eath certific attending pl | N/ | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of p | regnancy | | | | | 23d. Date of d | felivery |
| ĕ | atter for u | ciar | in the past 12 months? | 1 Live birth 2 ☐ 4 Pregnant at time | | 3 ☐Ectopic 5 ☐ Other (s | | | | Month | Day Year |
| o. | thet the de ed by the a detached f | ysi | 1 Yes 2 No 9 Unknown | 9□ Unknown | | | | | | | |
| ٣. | thet | | Part II. Other significant conditions co | ntributing to death but n | ot resulting in | the underlying | cause given | in Part I. | 23e. Did t | obacco use contribute | to the cause of death? |
| Ş | puires n sign lid be | d by | (1) Typo I DI | n · | | | | | 10 | Yes 212 No 3□ | Probably 4 Unknown |
| င္ပ | w requires thei s been signed b s should be det | lete | 2) Lower G | I Blees | 0_ | | | | 24a. Was | an 24b. Were | autopsy findings available |
| æ | he lav e has | Completed | 5 6 5 11 | | | | - | | | osy prior to ormed? death | o completion of cause of ? |
| | in: T | Ö | 25. Was case referred to medical | neve Res | nace | ment | | C Place of Do | 1 ☐ Yes ath (Check only o | 200 No 1 □ Y | es 2 No |
| ≒ | Attending Physicien: or death. ector: After this certifice by the funeral director, I | OB | examiner? | Hospital: | 2□ EB/Out | patient 3 🗆 🗅 | Other | | | dence 6 □Other (Si | naciful |
| ō | a Phy erthi | n:T | 27. Manne of Death | 28a. Date of Injury (Month, Day Ye | | me of | 28c. Injury at Work? | | | how injury occurred | Journal |
| <u></u> | aft. B fun | atio | 1 | (Month, Day Ye | a <i>r)</i> In | jury M | | s 2 □No | | | |
| N N | Attendi r death. ector: A by the fu | Ę | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Injury | | m, street, facto | ry, office | | | Street and Number or | Rural Route Number, |
| á | et or A s efter if Dire | Certification; | 4 Homicide | building, etc. (S | респу) | | | | City or To | wn, State) | |
| | pspit hour: uners y fille | 100 | 29a. Certifier 1 Certifying Phy | sician: To the best of m | y knowledge, | death occurre | d at the time, | date and place | e, and due to the | cause(s) and manner | as stated. |
| | To the Hospitel or Attending Physicien: The within 24 hours either death. Within 24 hours either death. Completely filled in by the funeral director, page | edical | (Check only 2 Medical Exami | ner: On the basis of exa and manner stated | unination and | vor investigatio | n, in my opini | ion, death occi | urred at the time, | oate and place, and d | ue to the cause(s) |
| | withii To th | Σ | 29b. Signature and title of certifier | | | | c. License n | | | 29d. Date signed (Mo | |
|) | | | 1611. Ulum | | | i ' | D213 | | | 1//17/0 | |
| | | | 30. Name and address of person who co | ompleted cause of death | (Item 23a) (| Type, Print) | 4 | <i>(</i> *) | | | . 1 |
| | | | KINK. WUN | 1 415 W | astring | ston A | we. | Ches | terlows | L, MD | 21620 |
| | Sta | | 31. Date filed (Month, Day, Year) | 32. Registrar's | Signature | nade p | | | | | |
| | Registr | ar | NOV 2 8 2006 | fill all some | 5" 5 | Company of the Compan | | | | | |

| | | | For State Registrar | ate of Maryla | | ificate of | | | g. No2 () () { | 37560 |
|------------|--|----------------|--|--|--|--|---|--------------------------------------|--------------------------|--|
| | Physicia | an | Decedent's Name (First, Middle, Last) | | | | | Date of Death Month | Day Yea | |
| | /Medic | | William Franklin | | | | | 11/23/ | 2006 | 9:00 P ^M |
| | Examin | er | 4a. Facility Name (If not institution, give street | | | | r Location of Death | | 4c. County of D | |
| and to | | 0 | Baltimore Washing 5. Social Security Number 6. Sex | · | ast birthday) | If Under 1 Year | Burnie | 8. Date of Birth | Anne A | |
| | Funeral Director | | 218-34-1475 |) T = ' ' ' | 59 Yrs. | Months Days | Hours Min. | (Month, Day, 11/01/ | 1937 | Birthplace (State or Foreign Country) MD |
| | /land ow at | | 10a. State 10b. County | 10c. C | ity, Town or Loc | ation | | | | 10d. Inside City Limits |
| | Many a-f sh ifled | ţo | MD Anne Arun | del (| Glen Bu | ırnie | | | | 1 ☐ Yes 2 ☑ No |
| | th the | Director | 10e. Street and Number | | | 10f. Zip Code | | 10 | g. Citizen of What | Country? |
| | 23a ust.b | la l | 7705 B & A Blvd. | | | 2106 | 0 | | U.S.A. | |
| | redea tems | Funeral | A A | as Decedent Ever in I | U.S. 13. W | as Decedent of H Yes, specify Cuba | lispanic Origin? (Sp an, Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Race - A Black, W | merican Indian, hite, etc. |
| 215-0036 | be filed within 72 hours after death with the Maryland ital Hygiene. Ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at | þ | If | Mares 2 No 19 Yes, Give ear or Dates: 19 | 958 - 966 | □Yes 2121No | Specify: | | Specific | White |
| ה ה | 72 hc 'natu dical | Be Completed | 15. Decedent's Education (Specify only highest grade con | ppleted) | 16a. Decede | ent's Usual Occup | oation during most of work d) | ing 1 | 6b. Kind of Busine | ss/Industry |
| 7 | within 72 iene. than "na he Medic | dm | Elementary/Secondary (0-12) C | ollege (1-4or 5+) | | o nor use retired eman | d) | 1 | Chomian | 1 Diant |
| N | filed v Hygie Sther 1 | ပ္ပိ | 17. Father's Name (First, Middle, Last) | | I OT | eman | 18. Mother's Name | | Chemica | 1 Plant |
| Maryland | d be ental ked o c eve | To Be | William Franklin | Miller | | | Viola | | , | |
| <u></u> | 2 should be and Menta Is marked raumatic ev | F) | 19a. Informant's Name/Relationship (Type. F | | 19b. Mailing | Address (Street | and Number or Rur | | City or Town, State | e, Zip Code) |
| | s t and 2 should f Health and Mer tem 27 Is marke other traumatic | | Patsy Gibson/Fiam | nce | 7705 | B & A | Blvd., (| Glen Bu | rnie, M | D 21060 |
| ē, | es 1 and of Health f ftem 27 r other ti | | 20a. Method of Disposition | 20b. | | tion (Name of atory or other place | | | 0c. Location - City | |
| Ĕ | Page nent c | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify) | al trom State | | - | Pk 11/2 | 27/06 | Glen Bu | rnie, MD |
| Baltimore, | permit. Pages 1 Department of H Important: If ite any Injury or ot | | 21. Signature of Pineral Servi, Licensee | _ | | | | | | 1 Home, PA MD 21122 |
| | og ≪ | | 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca | ns that caused the dea | | | | | | Approximate Interval Between |
| | Physician | 7 | Immediate Cause (Final | CAHDIO — (| DLMA | (ARY | ARREST | • | | Onset and Death |
| | /Medical | | disease or condition resulting in death) | Due to (or as a conse | equence of): | | | | | |
| | Examiner | | Property Bull and the same the | CAFDIO- | MYOPAT | CHY | | | | |
| | D # | Examiner | E-quartistif let sonditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a conse | equence of): | | £A(1) | 12 | | |
| | ecute and trans | cam | Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conse | ave | HEAR | 711100 | | | |
| 68/60, | death certificate be executed e attending physician and id for use as the burial-transit | al E | | ANEMIA | equence or). | | | | | |
| 200 | tificate ig phys as the | Medical | d | | | | | | | |
| ž | n cert | M/n | | yes, outcome pf pregi | | | | | 23d. Date of | delivery |
| C | w requires that the death cer been signed by the attendir should be detached for use | Physician/ | in the past 12 months? | □Live birth 2□Fe □Pregnant at time of □Unknown | | Ectopic pregnancy Other (specify) | у | | Month | Day Year |
| 7 | that the ded by detac | | Part II. Other significant conditions contribu | ing to death but not re | sulting in the und | derlying cause giv | en in Part I. | 23e. Did toba | acco use contribute | to the cause of death? |
| ecords, | law requires that the as been signed by th 2 should be detache | ted by | | | | | | 1 □ Yes | s 2□No 3□ | Probably 4 Donknown |
| Zec | e la has | Completed | | | | | | 24a. Was an autopsy perform | prior ed? death | autopsy findings available to completion of cause of ? |
| VITAI | Iclan: Th certificate ector, pag | | 25. Was case referred to medical | | | | 26 Place of Boot | 1 Yes 2 h (Check only one | □ No 1 □ Y | es 2□No |
| | S | To Be | examiner? 1 ☐ Yes 2 ☑ No Hospit | al: 1 ☐ Inpatient 2 | ER/Outpatient | 3□ DOA Oth | er | | nce 6 Dother (S | necity) |
| סר | g Ph ter thi | | | a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injur Wor | | 28d. Describe hov | | pocity |
| 0 | Attending r death. ector: Afte by the fune | atio | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation | (Intolial, Day Teal) | Injury | | Yes 2 □ No | | | |
| UIVISION | al or Attendi after death. I Director: A d in by the fu | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28 | e. Place of injury - At building, etc. (Spec | home, farm, stree | et, factory, office | | 28f. Location (Stre City or Town, | | Rural Route Number, |
| | To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral or | | 29a. Certifier 1 Certifying Physician (Check only 2 Medical Examiner: | a: To the best of my kr | nowledge, death | occurred at the tirestigation, in my o | me, date and place, | and due to the car | use(s) and manner | as stated. |
| | thin 2, | Medical | | ind manner stated. | 1 | 29c. Licens | | | d. Date signed (Mo | |
| | To To | | A MILLS | - pfuls | SICIAN | | | / | | |
| Ĺ | 1 | | 30. Name and address of person who comple | tod course of death /li- | am 22c) /T D | rint) · | 1170 | | 124/00 | |
| 1) | 1 | | Ali7 MANETWAI | A MA | / 3/7 / | PALL H | LOV. S.F. | Golon F |), rain 1 | ND 21061 |
| | Sta | te | 31. Date filed (Month, Day, Year) NOV 2 8 2006 | 32. Registrar's Sign | nature | A HINE IN | <i></i> | Uprest K | us rive , " | 1001 |
| | Registr | | NUV 2 8 2006 | CHECKS SU. | A STATE OF THE PARTY OF THE PAR | 0 | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 18, 2006 10:00 AM Colleen Marie Mooney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harkord 76 Cattail Lane Edgewood If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🕱 F 50 Sept. 3, 1956 Maruland Director 218-68-5248 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Edgewood Maruland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 76 Cattail Lane 21040 S. A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 MYes 2 □ No If Yes, Give Year or Dates: 1 YNever Married 2 Married 1 ☐ Yes 2 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Harford County Board College (1-4or 5+) 2 Years Elementary/Secondary (0-12) of Relators Secretaru 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Mooney Dolline Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8709 Maravoss Lane, Baltimore, Maryland 21234 Dolline Serra (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 11/22/2006 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Europal Service 17,975 Schimunek Funeral Home of Bel Air Inc. 610 W. Macphail Rd., Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Myowled disease or condition resulting in death) Due to (or as a consequence of): an Sequentially list conditions, in the same tendential cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2√No 24a Was an 2 X No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 28c. Injury at Work? 27. Manner of Death 28b. Time of

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it e Medical Examiner must be netitlied at

Baltimore, Maryland 21215-0036

the burial-transit the attending physician ate has been signed by page 2 should be detach After this certificate has

Division of Vital Records, P.O. Box 68760,

Physician:

Hospital or Attending

Director: /

within 24 hours For To the Funeral

filled in by

Medical

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

06

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🕼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifie

29c. License number 29d. Date signed (Month, Day, Year) 134931

, mD 21236 Dr. Ann C

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltmure ROI B-Sast

31. Date filed (Month, Day, Year) NOV 2 8 State Registrar

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

5 Pending

investigation

6 Could not be determined

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day . 45 PM Month Year **Physician** Mitchell Dolores V. 23 06 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ECICLE 1timurE Hospita Ran Klin WARE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 13, 1931 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number A SAY Months Days Hours 1 □ M 20 F Yrs. MAryland 219-56-3862 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 TNo MD Baltimore Middle River Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21220 6509 Ebenezer Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 28 No Specify: Specify: White ፩ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) own home Homemaker 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Sordelet Virginia C. Hickman ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6509 Ebenezer Road Baltimore MD 21220 Roger Mitchell /son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 11/28/06 Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Baltimore MD 21. Signature of Fur eral Service License, Connelly Funeral Home of Essex 23a. Part I. Enter the disease, of combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SOUPRE SEDSIS Due to (or as a consequence of): Meutro Denia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner HODG KIN Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Box 68760, attending physicien for use as the buria ned by the a P.O. bengis Division of Vital Records, director, page 2 should be has this within 24 hours after death.
To the Funerel Director: After thi
completely filled in by the funeral To the

Funeral

Director

r than "neturel", or iteme 23s or 28e-f ehow the Medical Examiner roust be notified at

with the Maryland

death

hours after

filed within Hygiene. other than "

12 should be fi n and Mental H 1s marked otl

permit. Pages 1 and 2 should be Depertment of Health and Mental Important: If Item 27 is marked 1 eny injury or other treumatic events.

other

| 12 | | |
|----|--------------|--|
| Re | Sta gistr | |

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Baytimore, MD Shabani Klin 31. Date filed (Month, Day, Year)
NOV 2 8 2006 32. Resistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Nov. Idell L. McCullah 24 2006 5:35a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 418 Carroll Island Road Middle River Baltimore | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 9. Birthplace (State of Country) | March 8, 1943 | Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2□F 219-38-8459 63 Director Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 ie marked other then "naturel", or iteme 23a or 28a-f ehow eny injury or other traumatic event, the Medical Examinat must be notified at MDBaltimore Middle River 1 ☐ Yes 2 XNo Director 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 418 Carroll Island Road 21220 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Give kind of work done during most of working Ut Kife. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dennis D. Littlejohn Nellie Mae Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas L. McCullah/husband 418 Carroll Island Road Balto. MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 20c. Location - City or Town, State Gardens of Faith 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/27/06 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 300 Mace Ave.Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** breast Carico disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner signed by the attending physicien and I be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Day 4☐Pregnant at time ol death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peed 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death? page 2 s has autopsy performed? 1 Yes 2 19 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physicien: efter death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manper of Death 28d. Describe how injury occurred Certification: Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours e To the Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

State

Registrar

301 St. Parl

D40854

Buttinone 21202

11/27/2006

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Riseberg

2006

31. Date filed (Month, Day, Year)

NOV 2 8

| | | | For State Registrar | | State o | f Marylar | nd / Depa | artmen rtificati | t of H e of L | ealth a | and M | lental Hy | giene Reg. No. | | 37564 |
|------------|---|------------------|--|-------------------------|----------------------------|-------------------------------------|---------------------------------|--|-------------------|---------------------|------------|---------------------------------|-------------------|--------------------------|-----------------------------------|
| | DI | | 1. Decedent's Name (First, | Middle, Las | t) | | - | | | | | 2. Date of De. Month | ath Day | / Year | 3. Time of Death |
| | Physici /Medic | | Helen E. | M | itchel] | <u>-</u> | | | | | | Novembe | | | 10:45 P ^M |
| | Examin | | 4a. Facility Name (If not inst | itution, give | street and nu | m <i>ber)</i> | | 4b. City, | Town, or | Location of | of Death | | 4c. | County of Dea | th |
| | | | Golden Year | | | | | Mt A | | 17.1.1 | 2411 | | | lontgom | |
| | Funeral | | 5. Social Security Number | 6. Se | ex □M 2X0F | 7. Age (In yrs. | last birthday) Yrs. | If Under Months | Days | If Under Hours | Min. | 8. Date of Birt (Month, Da | v, Year) | 9. Bir | thplace (State or Foreign ountry) |
| | Director | | 135-54-6097 Usual Residence of Decede | | | 93 | 115. | | | | | Sept. 2 | 26, | 1913 Ne | w York |
| | and w | | 10a. State 10b. C | | | 10c. Ci | ty, Town or Lo | cation | | | | | | | 10d. Inside City Limits |
| | Mary feho | ō | Maryland Mon | tgome | 277 | M+ | Airy | | | | | | | | 1 ☐ Yes 2 No |
| | the 288 | e C | 10e. Street and Number | LEGOME | Ly | IIIC 2 | CILLY | 10f. Zip | Code | | | | 10g. Citi | izen of What C | ountry? |
| | 3a or | Funeral Director | 28928 Ridge | Road | | | | 21 | 771 | | | | U.5 | S.A. | |
| | death ms 2 | era | 11. Marital Status | noud | 12. Was Dec | edent Ever in U | J.S. 13. | | | spanic Ori | igin? (Sp | ecify Yes or No Rican, etc.) | | 14. Race - Ame | |
| ယ္ | after or the | 큔 | 1 Never Married 2 | Married | Armed Fo | 2 ⊠ No | | ni Yes, speo 1 □ Yes | | | | Hican, etc.) | | Black, Whi | te, etc. |
| 21215-0036 | within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f ehow ta Madical Exandra must be malified at | Completed by | 3 X Widowed 4 ☐ Div | orced | If Yes, Gir Year or D | ates: | | 1 🗆 165 | 224 140 | эрөспу. | | | | Specify: W | hite |
| 5-0 | 72 ho | etec | | edent's Ed | ucation de completed) | | 16a. Dece | dent's Usua kind of wo DO NOT us | al Occupa | ation during mos | at of work | ing | 16b. Ki | ind of Business | /Industry |
| 21 | ithin | ηpi | Elementary/Secondary (0 | - | College (| 1-4or 5+) | | | se retired |) | | | М- | 12 - 2 | |
| 2 | filed w Hygier other ti | | 17 Fethoda Nama (First 14 | iddle (ast) | 2 | | 1 1 | Nurse | | 19 Moth | or's Name | e (First, Middle, | | dicine | |
| and | be fi | Be | 17. Father's Name (First, M Michael Hag | | | | | | | | know | , | , Marcen | Julianie) | |
| Maryland | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: if item 27 is marked other then "natural; or items 23a or 28a-f ehow any injury or other traumatic event, the Mudical Experience must be notified at ance. | ဥ | 19a. Informant's Name/Rel | | Tuna Print | | 19b Maili | na Address | (Street | | | al Route Numbe | er City o | or Town State | Zin Code) |
| Ma | d 2 sl th an 7 is r traur | | John Mitche | | Son) | | | - | | | | ood, NJ | - | | 2.6 0000) |
| | 1 and Health em 27 | | 20a. Method of Disposition | 11 (| BOIL | 20b. l | Place of Dispo cemetery, cre | | | | - | Date No | | ocation - City or | Town, State |
| ō | Pages nent of I int: If its iry or o | | 1 Burial 2 □ Crem | | | State | cemetery, cre. • Cathe | | | | 11/2 | 1/06 | Ua 1 | L1, NJ | |
| Baltimore, | permit. Pages Department of It Important: If ite eny injury or of | | 4 □ Donation 5 □ Ot 21. Signature of Puneral Se | | | bt | 2: | 2. Name ar | nd Addres | s of Facili | tv | | Wal | 11, 110 | |
| Ba | Depa Impo eny i | | 1/2 | - / | 2/1/1 | 2 | 1 3 | 3uckl | ev Fi | unera | l Ho | me sbury P | Dark | NI 07 | 712 |
| | | | 23a. Part1. Enter the disea | se, or com | plications that | aused the dea | | | | | | | | N3 07 | Approximate Interval Between |
| | Physician | | shock, or heart failure Immediate Cause (Final | . List only | one cause on | each line. | ild 1 | ME | R' | 6 | X | EME | CKI" | TIA | Onset and Death |
| 7 | /Medical | | disease or condition resulting in death) | - | aDue to | (or as a consec | quence of): | 10 | , | | | Ciric | -14 | | |
| | Examiner | | | - 1 | b | | | | | | | | | | |
| | | ner | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | •] | Due to | (or as a consec | quence of): | | | | | | | | |
| / | cutec | Examiner | Cause (Disease or injury that initiated events | 1 | c | | | | | | | | | | |
| 0 | e exe len a urial-1 | Ä | resulting in death) Last | | Due to | (or as a consec | quence of): | | | | | | | | |
| 8760, | law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit | Icai | | | d | _ | | | | | | | | | |
| 99 | ing p | Physician/Med | IF FEMALE: | | | .002 | | | | | | | | | |
| Box | ath ce ttend or us | lan/ | 23b. Was decedent pregna in the past 12 months | | 1 Live I | tcome of pregn pirth 2 Pet | al death 3 | □Ectopic p | | , | | | | 23d. Date of de Month | elivery Day Year |
| o. | the a | /sic | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | | 4∐Preg 9□Unkr | nant at time of o | death 5 | Other (sp | oecity) | | | | | | |
| P.0 | hat the deby | P. | Part II. Other significant co | anditions o | ontributing to c | eath but not re | sulting in the u | ınderlyina | ause div | en in Part I | l. | 23e. Did t | tobacco i | use contribute t | to the cause of death? |
| ds, | uires that the dei signed by the a Id be detached f | å by | | | | | | , , | | | | 10 | Yes 2 | X 0 No 3 □ P | robably 4 Unknown |
| Records, | w require been si should b | Completed | | | | | | | | | | 240 1460 | | Jah Wara a | utopsy findings available |
| 3ec | e law has l | ig E | | | | | | | | | | 24a. Was auto perfo | | prior to death? | completion of cause of |
| a | Physician: The lav this certificete has al director, page 2 | | | | | | | | | | | 1 Tes | 2 🔯 No | 1 ☐ Ye | |
| Vital | Physician: this certific ral director, | Be | 25. Was case referred to n examiner? | nedical | Hospital: | | 7 | | Oth | 20 | | h (Check only o | | -h-6. | ASCT |
| to | Phys this al dir | 2 | 1 ☐ Yes 2 No 27. Manner of Death | | 1 | Inpatient 2 | ER/Outpatie 28b. Time of | | JA | 4 🗆 1 | ursing Ho | me 5 Resi | | 6' ther (Spent | ecity) |
| L | nding ath. r: After e funer | S C | 1 Natural 5 | Pending nvestigation | | of Injury nth, Day Year) | Injury | м | 28c. Injun Wor | k?¨ Yes 2.⊡ |]No | | , | , | |
| isi | Attending death | lca | 3 ☐ Suicide 6 ☐ | Could not b | e Jan Blac | e of Injury - At h | home, farm, st | | | | | 28f. Location (| Street ar | nd Number or F | Rural Route Number, |
| Division | or A effer Dire | Certification: | 4 Homicide | determined | build | ing, etc. (Spec | ify) | , | ,, | | | City or To | wn, State | 9) | |
| | To the Hospital or Attending Ph within 24 hours effer death. To the Funers! Director: Affer th completely (illed in by the funeral | | 29a. Certifier 1X Co | rtifying Ph | nysician: To th | e best of my kn | nowledge, dea | th occurred | at the tir | ne, date a | nd place, | and due to the | cause(s |) and manner a | as stated. |
| | P Ho | edicai | (Check only 2 Mi | dical Exar | niner: On the t and mar | pasis of examination of the stated. | ation and/or in | nvestigation | n, in my o | pinion, de | ath occur | red at the time, | , date an | d place, and du | e to the cause(s) |
| | To th To th comp | ž | 29b. Signature and little of | certifier | M1 | | | 29 | c. Licens | e number | | | 29d. Da | ite signed (Mon | oth, Day, Year) |
| | | |) Ife | w | WIT | 1/2- | | - 7 | 0 0 | 0 6 | 311 | 45 | 11 | 116 | 106 |
| | 10 | | 30. Name and address of p | erson who | completed cau | se of death (Ite | em 23a) (Type | , Print) | | | | | | 1 | |
| _ | Ψ | | ARVIA | D | 1)6 | SA) | 115 | Roes1 | er R | d., 0 | Glen | Bernie, | , MD | 21060 | |
| | St. Regist | ate | 31. Date filed (Month, Day | | 2006 | Poistrar's Sign | nature | park | 0 | | | | | | |
| | negisi | rei | K!f}/ | 178 | /111h | A STREET | 10 | 1 | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink 06-08516 State of Maryland / Department of Health and Mental Hygiene Diane K. Morell Certificate of Death 1. For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day November 8, 2006 1810 hrs Medical Examiner Kemack Morel1 Diane 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Rockville Montgomery Shady Grove Hospital If Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Months Days Hours Min Director Countyew York 094-22-8426 M 2X F 77 1929 6 Sept. Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location any 10b County 1 X Yes 2 No 28a-f show Montgomery Village Maryland Montgomery rector death with the Maryland 10f. Zip Code 10g Citizen of What Country? 10e Street and Number notified at 23a or 3 20886 U.S.A. ā #103 9801 Feathertree Terrace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S must be Armed Forces' Never Married 2 X Married 2 X No Yes permit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", of injury or other traumatic event, the Medical Examiner m White 1 Yes 2 X No specify: Widowed Divorced f Yes, Give Year Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) eted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Own Home 2 Homemaker Com 1B.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Lillian Reck Kemack Be Abe Kemack 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9801 Feathertree Terrace #103
Montgomery Village, MD 20886 19a Informant's Name/Relationship (Type, Print) Nathan Morell (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a Method of Disposition crematory or other place) Burial 2 Cremation 3 Nov. 17,06 Knoxville, TN Univ. Of Tennessee 4 X Donation 5 Other Specify 23 Name and Address of Facility anthropology
University of Tennessee
250 S. Stadium Hall, Knoxy
nter the mode of dying, such as cardiac of respiratory ares 21. Signature of Funeral Service I cere meen Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter Physician Between Onset and failure. List only one cause on each line /Medical Death Hypertensive Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of) and ca UNPENDED AMENDED physician a The law requires that the death certificate be Physician/Medi Box 68760, 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Live birth 2 Fetal death Pregnant at time of death 5 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ⋧ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, P. Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Be Cther₄ examiner? DCA Nursing Home 5 Residence 6 Other Inpatient 2 FR/Outpatient 3 this ဥ 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b Time of Injury After 27. Manner of Death Certification: 1 V Natural Yes 2 No 5 Pending death Fo the Funeral Director: completely filled in by the Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 2Be. Place of Injury - At home, farm, street, factory, office building, etc 3 [6 Could not be Suicide determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b Sidnature and title of certifier November 10, 2006 O.C.M.E Woulderse 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

| | | | | For State Registrar | State | of Maryla | • | ertificate of | Health and Me <i>Death</i> | | iene 006 | 37566 |
|--------|----------------------------|---|-------------------|---|--------------------------------|--|----------------------------|---|-------------------------------|---------------------------------------|---|--|
| | | Physicia | an | 1. Decedent's Name (First, Midd | le, Last) | _ | | 26 | | 2. Date of Death Month | Day Year | 3. Time of Death |
| | | /Medic Examin | al | Helen 4a. Facility Name (If not institution | n, give street and n | L. u <i>mber</i>) | | Martin 4b. City, Town, | or Location of Death | 400 FIND | 4c. County of De | |
| | | Examin | er | 2 | FEFFINGTON | | ALCEA | | EN BURNI | | ANNE | ARUNDEL |
| | | Funeral | | 5. Social Security Number 274-24-2533 | 6. Sex 1 ☐ M 2 🖾 F | 7. Age (In y | rs. last birthday Yrs. | Months Days | Hours Min. | B. Date of Birth (Month, Day, Nov. 12 | Year) (| inthplace (State or Foreign Country) Ohio |
| | | Director | | Usual Residence of Decedent | | | | | | NOV. 12 | ,1921 | |
| | | death with the Maryland rms 23a or 28a-f show r must be notified at | _ | 10a. State 10b. Count | | 10c. | City, Town or L | | | | | 10d. Inside City Limits 1 X Yes 2 □ No |
| | | he Ma | Director | MD Anne 10e. Street and Number | Arunde1 | | Gambri | 11s | | 1/ | 0g. Citizen of What (| |
| | | with (| Dir | 1704 Saddle D: | cive | | | 21054 | | | USA | Southly. |
| | | after death w or items 23a | Funeral | 11. Marital Status | | cedent Ever in | n U.S. 13 | . Was Decedent of | Hispanic Origin? (Spec | ify Yes or No- | 14. Race - An Black, Wh | nerican Indian, |
| \geq | 36 | filed within 72 hours after Hygiene. ther than "natural", or ite ont, ite Medical Examina | by Fu | 1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce | ried 1 ☐ Yes | 2 XNo | | 1 ☐ Yes 2 ☒ No | | , 5(5.) | | White |
| F | 9 | tura! | ed p | | Year or | Dates: | 16a. Dec | edent's Usual Occu | pation | | 16b. Kind of Busines | s/Industry |
| MARTI | 21215-0036 | thin 72 e. en "na | nplet | (Specify only higher Elementary/Secondary (0-12) | est grade completed College | (1-4or 5+) | (Giv life. | re kind of work done DO NOT use retire | during most of working ad) | 7 | | |
| Q | 21 | e filed with al Hygiene. other than vent, IL.e M | Con | 8 17. Father's Name (First, Middle | (act) | | Food | d Service | 18. Mother's Name (| First Middle A | Hospital | |
| 2 | Maryland | ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a Medical Exatinar must be notified at | To Be Completed | Leslie Durwood | | | | | Helen Ir | | | |
| | aryl | 2 should be fi and Mental H is marked of raumatic ever | - | 19a. Informant's Name/Relation | ship (Type, Print) | | 19b. Mai | iling Address (Stree | t and Number or Rural | | | Zip Code) |
| 9 | | s 1 and 2 of Health a item 27 is | | Judy Aufderhei | de | 200 | | | Drive Gamb | | | |
| Jelen | nore | Pages 1 nent of H int: if ite iry or oti | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation | | II State | | position (Name of ematory or other pla Cemetery | 12-2-0 | | 20c. Location - City $\mathfrak Galloway$, | |
| - | altimore, | 그 든 원 중 | | 4 □ Donation 5 □ Other (21. Signature of Funeral Service | | | | • | ess of Facility Tidd | Funera | al Home | |
| | Ä | Department | | Julen | Den | elk | | | 5265 | Norwic | ch St. Hil | liard, OH |
| _ | | | | 23a. Part1 Enter the disease, of shock, or heart failure. Lis | t only one cause or | each line. | | | | | | Approximate Interval Between Onset and Death |
| | | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a. SQU | o (or as a con | CELL (| ARUNOM | NA OF TH | E Cun | K | |
| | | Examiner | | | b | 0 (01 a3 a con | sequence or, | | | | | |
| | | # W # | Iner | Sacuentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due t | o (or as a con: | sequence of): | | | | | |
| | | sicien and burial-transit | Examiner | that initiated events resulting in death) Last | c | o (or as a con: | sequence of): | | | | | |
| | 8760, | ate be ex hysicien the buria | | | d | | | | | | | |
| | 9 | certificat nding phy use as th | Medi | IF FEMALE: | | | | | | | | |
| | Box | eath cer attendin for use | Physiclan/Medical | 23b. Was decedent pregnant in the past 12 months? | 1 Live | outcome of pre birth 2 F gnant at time | etal death 3 | B Ectopic pregnand | су | | 23d. Date of d Month | elivery Day Year |
| | P.O. | that the de ed by the detached | hysic | 1 □ Yes 2 ☑∕No 9 □ Unknown | 9□Unl | | 0. 404 | Janes (speeding) | | | | |
| | | 8 53 | ð | Part II. Other significant condit | ions contributing to | death but not | resulting in the | underlying cause g | iven in Part I. | 23e. Did tob | | to the cause of death? Probably 4 Sunknown |
| | Division of Vital Records, | aw requir is been si 2 should | Completed | | | | | | | 24a. Was a | n 24b. Were | autopsy findings available o completion of cause of |
| | E P | The I | Com | | | | | | | perform | ned death | ? es 2□ No |
| | Vita | atcian: The certificate rector, pag | Be | 25. Was case referred to medic examiner? | Hospital | | | 10 | 26. Place of Death | | | |
| | þ | Phya arthis eraldi | To to | 1 ☐ Yes 2 ☑ No 27. Manner of Death | 28a. Da | Inpatient : te of Injury onth, Day Yea | 2 ER/Outpati 28b. Time | of 28c. Inju | 4 Nuising Hom | | ence 6 Other (S) ow injury occurred | pecify) |
| | ion | tanding leath. tor: After the funer | atlo | E / too do nt | tigation | ontn, Day rea | r) Injury | | ork? □Yes 2□No | | | |
| | ivis | or Attar fler de Directo | Certification: | 3 ☐ Suicide 6 ☐ Coule 4 ☐ Hornicide deter | minord 288. Pld | ce of Injury - Ailding, etc. (Sp | At home, farm, : ecify) | street, factory, office | 2 | Bf. Location (St. City or Town | | Rural Route Number, |
| | | spitel or ours efte nerat Dir filled in | | 29a. Certifier 1 Certify | ing Physician: To: | the best of ww | knowledga da | ath oppured at the | tivie, data and place, a | nd due to the ca | ause(s) and manner | as stated. |
| | | To tha Hos within 24 h To the Fur completely | edical | (Check only 2 Medics | I Examiner: On the | basis of exam anner stated. | nination and/or | investigation, in my | opinion, death occurre | d at the time, d | ate and place, and d | ue to the cause(s) |
| | | To t To t | Σ | 29b. Signature and title of certif | er la - | | -mi | 29c. Licer | nse number | 1 | 9d. Date signed (Mo | ntin, Day, Year) |
| | | 7 | | Maine and a dress of perso | n who complet | use of death | (Item 23a) (Typ | e Print) | 12), (_1 | | 10+CM Ger | 7 200 |
| | | | | CN49110 | 301 H | rosputs | al Dr | 100 G | ten Bu | rnie | MUD 3 | 1061 |
| | | Sta Regist | | 31. Date filed (Month) Day, Yea | 7) 32 2 8 2006 | . Registrar's S | ignature | Spelled) | | | | |

| | | | State of Maryland / Depa 1- State Registrar AmEND #8&9 Per FH G862 12/08/706 | rtment of Health and I titiente of Death | Mental Hygier | ^e 2006 37567 |
|-------------------|--|------------------|--|--|---|--|
| - | | | Hegistrar AllEND #ORD TELL FIT GOOZ 12/00/90 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death | 3. Time of Death |
| ı | Physicia | | Steven Jay Mandell | | Nov. 22, | Day Year |
| and Stanger | /Medic Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | c. County of Death |
| | | ó | Gilchrist Hospice | Towson | | Baltimore |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Yea | 1958 9. Birthplace (State or Foreign Country) |
| | Director | | 136-56-8872 X 47-48 | | Aug 23, 1 | 959 Passaic, NJ |
| | land ow | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc | cation | | 10d. Inside City Limits |
| | Mary -f sh | ţ | MD Baltimore Baltimo | re | | 1 ☐ Yes 2 ☐ No |
| | n 28a | irec | 10e. Street and Number | 10f. Zip Code | 10g. (| Citizen of What Country? |
| | th wit | Funeral Director | 6128 Allwood Court | 21210 | l u | SA |
| | r dea ems | ne | 11. Marital Status 12. Was Decedent Ever in U.S. 13. V Armed Forces? | Vas Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerl | | 14. Race - American Indian, Black, White, etc. |
| 36 | s afte | by Fu | 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No ☐ If Yes, Give 1 | Yes 2☐No Specify: | | Specify: |
| 21215-0036 | within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at | q pe | | lent's Usual Occupation | 16h | White Kind of Business/Industry |
| 5 | in 72 n "na fedic | Completed | (Specify only highest grade completed) (Give | kind of work done during most of wor DO NOT use retired) | king | Time of Business/madsity |
| 212 | J with giene r tha the N | E | Elementary/Secondary (0-12) College (1-4or 5+) 4+ At 1 | torney | L | aw |
| | al Hy al Hy othe | BeC | 17. Father's Name (First, Middle, Last) | 18. Mother's Nam | ne (First, Middle, Maid | en Surname) |
| yla | ould by Ment arkec | 2 | Jack Mandell | | Lavor | |
| Maryland | s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | | | g Address (Street and Number or Ru | | |
| | 1 and Healt em 2 | | | armer Terrace Wa | · · · · · · · · · · · · · · · · · · · | 7470 Location - City or Town, State |
| Baltimore, | permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once. | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Solo | | 26/06 | • |
| 量 | nit. F partme ortan Injur | | | . Name and Address of Facility | 1 01 | ifton, NJ |
| m | Depar Impor any Ir | | pien Glendle | Eden Memorial Ch 327 Main Street | apels Fort Lee, | N.I 07024 |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not ente | | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | with meta | istases | Onset and Death |
| | /Medical Examiner | | resulting in death) Due to (or as a consequence of): | | | 0 |
| 8 | ₹. | <u>.</u> | Sequentially list conditions, if any reading to immediate b. | | | |
| - k | uted 3 ansit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | |
| 0 | an an | Exa | resulting in death) Last Due to (or as a consequence of): | | | |
| 28160 | icate be executed physician and s the burial-transit | dical | d | | | |
| _ | | | IF FEMALE: 23c. If yes, outcome pf pregnancy | | | |
| Box | death certifis e attending p ed for use as | Physician/M | in the past 12 months? | Ectopic pregnancy Other (specify) | ď | 23d. Date of delivery Month Day Year |
| P.O. | - w Σ | ysie | 1 Yes 2 No 9 Unknown | outer (specify) | | |
| | law requires that the de as been signed by the a 2 should be detached f | by Pt | Part II. Other significant conditions contributing to death but not resulting in the un | nderlying cause given in Part I. | 23e. Did tobacc | o use contribute to the cause of death? |
| rds | w require been sig should b | | | | 1 ☐ Yes | 2 No 3 Probably 4 Unknown |
| Records, | ne law requ has been je 2 should | Completed | | | 24a. Was an autopsy | 24b. Were autopsy findings available prior to completion of cause of |
| E | Page ⊒ | E | | | performed 1 Yes | death? |
| /ita | ilclan; Th certificate ector, pag | Be (| 25. Was case referred to medical examiner? | 100 | th (Check only one) | |
| or | | 2 | 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien 27, Manner of Death 28a. Date of Injury 28b. Time of | | | 6 Cother (Specify) LOSPICE |
| uo | dlng h. After funer | ion | Natural 5 Pending (Month, Day Year) Injury | 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No | 28d. Describe how in | jury occurred |
| Division or Vital | Atten r deat ector by the | fica | 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, stre | | | and Number or Rural Route Number, |
| Ö | s after | Certification: | 4 Homicide determined building, etc. (Specify) | l, | City or Town, Sta | ate) |
| | Hospit 4 hour Funera ety fille | edical (| 29a. Certifier (Check only (Ch | n occurred at the time, date and place vestigation, in my opinion, death occu | , and due to the cause irred at the time, date a | (s) and manner as stated. and place, and due to the cause(s) |
| | To the Hospital or Attending Physimithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di | Med | one) and manner stated. 29b. Signature and title of certifier | 29c. License number | 29d [| Qate signed (Month, Day, Year) |
| | ≓ ₹ ₹ 8 | | Dendago Olamon | 1) 25643 | u | 23/2006 |
| | 91 | ŀ | 30. Name and address of person who completed cause of death (Item 23a) (Type, I | Print) | 3 | |
| | \ | | Hendall R. Faulknerm D/6601 N. | Charles Stept/ | Deltow | 21204 |
| | Sta Registr | | 30. Name and address of person who completed cause of death (Item 23a) (Type, I Werdcell R Faultener mD 660 i N. 31. Date filed (Month, Day, Year) NOV 2 8 2005 | parke | | |
| | The State of the S | 317 | 140 1 10 0 1000 3 | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5. 34MM 200 Robert Timothy Mahoney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number **Funeral** 1[**X**M 2□ F 6, Maryland 215-72-0002 Jan. 1958 Director 48 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 1 Serves 2 No Director Baltimore City Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 525 West 27th Street 2nd Floor 21211 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, Ih. Meone. Elementary/Secondary (0-12) College (1-4or 5+) 8 Textile Mills Mixer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William R. Mahoney Sr. Ruth Reindollar ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3939 Roland Ave. 414 Baltimore, MD 21211 Ruth Mahoney - Mother Apt. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov. 28, 06 Baltimore, MD Metro Crematory 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 21. Signature of Funeral Service Approximate Interval Between Onset and Death 23a. Paul . Enter the disease, or complications that caused the death. Do not enter the mo shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Due to (o Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9□Unknown 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 4 Unknown 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate the Hospital or Attending Physician: in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes npatient 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of eath Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral Completely filled in filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of pe

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day,

Carroll Hospital Center Westminster If Under 1 Year If Under 24 H Months Days Hours M 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗶 F Months Yrs. 216-30-9950 71 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County item 27 is marked other than "natural", or itsms 23s or 28s-f show other traumatic avent. the Martical Examinar must be motified at Director Maryland Carroll Sykesville 10e. Street and Number Of. Zip Code deeth with 4500 London Bridge Road 21784 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin?
 If Yes, specify Cuban, Mexican, Pu permit. Pages 1 and 2 should be filed within 72 hours after or Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itan any injury or other traumatic avent. The Medical Examinations. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 0 Assembler 17. Father's Name (First, Middle, Last) 18. Mother's N Be Lewis Almond Ros 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Carolyn A. Haines (Daughter) 4500 London Bridge R 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility I \$728 Liberty Road, Lem 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury is Exami stal that initiated events resulting in death) Last

McGehee

37569 3. Time of Death

0220 M

| minster | | Car | roll |
|--|--|----------------|--|
| ar If Under 24 Hrs. ys Hours Min. | 8. Date of Birth (Month, Day,) July 06, | | 9. Birthplace (State or Foreign Country) Maryland |
| | | | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No |
| ө | 100 | g. Citizen of | What Country? |
| 84 | Ųni | ited S | tates of America |
| of Hispanic Origin? (Specuban, Mexican, Puerto | crfy Yes or No- Rican, etc.) | 14. Rad Bla | ce - American Indian, ck, White, etc. |
| No Specify: | | Specif | y: White |
| cupation ne during most of worki tired) | ng 10 | 6b. Kind of B | usiness/industry |
| | | | nd Cup |
| 18. Mother's Name | | aiden Sumar | ne) |
| | Calbage | | |
| eet and Number or Rura | | - | |
| | | | , Maryland 2178 |
| Inc. 11/2 | 24/06 Ba | ltimo | re, MD. 21228 |
| | | | eral Directors,l aryland 21133 |
| dying, such as cardiac c | r respiratory arres | st, | Approximate Interval Between Onset and Death |
| balanc- ng cai | | | |
| incy | | | ite of delivery onth Day Year |
| given in Part I. | 23e. Did toba | | tribute to the cause of death? |
| | 24a. Was an autopsy performe | | Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |
| 26. Place of Death | (Check only one |) | |
| Other: 4 Nursing Hor | ne 5 🗆 Residen | ice 6 Oth | ner (Specify) |

4c. County of Oeath

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed ettending physicien end for use as the burial-trar Physician/Medical ģ page 2 should be Completed certificate Hospitel or Attending Physicien: Be After this Certification: within 24 hours after deeth. To the Funerel Director: A

IF FEMALE:

23b. Was decedent pregnap

in the past 12 mon

25. Was case referred to dical examiner?

1 Yes 2 No

27. Manne eath

1 Natural

2 Accident

3 Suicide

29a. Certifier

cal

4 Homicide

(Check only one)

9 Unknown

1 - For State Registrar

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn Grace

4a. Facility Name (If not institution, give street and number)

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

GIRDHAR, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

1. Inpatient

28a. Date of Injury (Month, Day Year)

4 Pregnant at time of death

Stower

3 Ectopic pregnancy

3 DOA

28c. Injury at Work?

1 Dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygien () [] [

4b. City, Town, or Location of Death

2. Date of Death

Month

NOV 2 8 2006

5 Pending

investigation

6 Could not be determined

06-08870 Jack M. Morgan

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

| ack IVI. IVIOIGAII | | - For State Celegistrar Celegistrar | rtificate of | | id Mentar i | | g. No. 200 | 6 27570 |
|---|----------------|---|-------------------------------------|--------------------------|--|--------------------------------------|-------------------------------------|--|
| Physicia Medical Examir | n/ | 1. Decedent's Name (First, Middle,Last) Jack M. Morgan, III | | | | Date of Death Month November | | 8. Time of Death |
| wedicai Examii | | 4a. Facility Name (if not institution, give street and number) | - 1 | b. City, Town, or | r Location of Death | | 4c. County of Dea | |
| ,/ | | 748 Shallow Ridge Court 5 Social Security Number | lest hirthday) | Abingdon If Under 1 Yea | ar If Under 24Hrs | 8 Date of Rict | Harford | Birthplace (State or |
| Funeral Director | | 5. Social Security Number 220-96-9149 1234 2 F 7. Age (In yrs. 120) Usual Residence of Decedent | 29 Yrs. | Months Day | | ⊣ | For | eign Country) Maryland |
| v any | İ | 10a. State 10b. County 10c. City | , Town or Locati | on | 71 ' 7 | | | 10d. Inside City Limits |
| faryland 28a-f show I at once. | 햜 | Maryland Harford 10e. Street and Number | | 10f. Zip Code | Abingdo | | g. Citizen of What Co | 1 Yes 2 X No |
| ith the Maryland 23a or 28a-f sho notified at once. | Dire | 748 Shallow Ridge Court | 10 140 140 | | 21009 |) | | USA erican Indian, Black, |
| more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examinger must be notified at once | Funeral | 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year | lf Y | | ispanic Origin? (S in, Mexican, Puerto | | White, etc. | |
| ours after attural". | d b | 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15 Decedent's Education (Specify only highest grade completed) | 16a, Deceden | t's Usual Occupa | ation (Give kind of e. DO NOT use ret | | 16b. Kind of Busines | s/Industry |
| 36 din 72 ho han "n dical Ex | Completed | Elementary/Secondary (0-12) | - during m | Disab | | ii ed j | N/ | A |
| e, MD 21215-0036 I and 2 should be filed within 72 Health and Mental Hygiene. iten 27 is marked other than ' | | 17. Father's Name (First, Middle, Last) | | | 18.Mother's Name | | laiden Surname) | |
| 2121 Id be fi Mental I narked event, | Be | Jack Morgan, Jr. 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing | Address (Stre | | Le Rohr | bach ber, City or Town, Sta | ate Zip Code) |
| MD 2 12 shou th and h 27 is n umatic | ٩ | Jack Morgan, Jr. Father | 748 5 | Shallow | Ridge | Ct. Ab | ingdon, | MD 21009 |
| Ore, es l and of Heal If iten | | 1 XX Burial 2 Cremation 3 Removal from State | Place of Dispos crematory or oth | ner place) | | Date | 20c. Location - City | |
| ·= . 6 2 9 1 | | 4 Donation 5 Other Specify. | 22 N | ame and Address | Mem . 1 | | Timoniu | · - |
| | 4 | 23. Part I. Enter he disease, or domplications that caused the death | Bu | rgee-H | lenss-Se ls Roac | itz Fu L Balt | neral Ho imore, M | me, Inc. D 21211 |
| Physician /Medical | | tailure. List only one cause out each line. | | | j, such as cardiac (| or respiratory arre | est, shock, or heart | Approximate Interval Between Onset and Death |
| Examiner | | Immediate Cause (Final disease or condition resulting in death) a. DITTUOTOETRANE 1 Due to (or as a consequence or condition) | | OH | | | | - |
| . E | ě | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence | of): | | | | | |
| , | Examiner | Colsease or injury that initiated events resulting in death) Last | of): | | | | | |
| 760, icate be executed physician and the burial - transit | SalE | d. AMENDED #1 222 2 | | | | | | |
| '60, ate be e obysician | Medical | #1,23a,77 IF FEMALE: 23c. If yes, outcome of pre- | | erME G863 | 3, 1/16/07 | IT | 23d. Date of deliv | ery |
| 687 certifica nding p | ian/ | 23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of d | | | Ectopic pregn | ancy | Month | Day Year |
| Box death the atter | Physician/ | 1 Yes 2 No 9 Unknown 9 Unknown | eath 5 Ot | ner (Specify) | | | | |
| Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certific rs after death. al Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the content of the desire of the content | | Part II. Other significant conditions contributing to death but not | resulting in the u | inderlying cause | given in Part I. | | | to the cause of death? |
| ds, l | Completed by | | | | | 24a. Was a | | autopsy findings available |
| ecor he law i ate has b | dwo | | | | | autop perfor 1 V Yes | med? death | |
| ian: T | Be C | 25. Was case referred to medical examiner? | | | ce of Death (Check | | | |
| of Vil | 2 | examiner? 1 V Yes 2 No 27. Manner of Death Hospital: 1 Inpatient 2 28a. Date of Injury | ER/Outpatient 28b. Time of I | | Other Nursi | | Residence 6 V Otl | her: Scene |
| OD C tending sath. or: Af | tion | 1 Natural 5 Pending Find 11/21/2006 | Fnd 10:25 | oam ¹□ | Yes 2 X No | unknowr | 1 | |
| ivisior d or Attend after death I Director: ed in by the | Certification; | 3 Suicide 6 X Could not be 28e. Place of Injury - At I | | | building, etc. | or Town, S | tate) 748 Shall | Rural Route Number, City Low Ridge Ct. |
| Hospita 4 hours Funeral | Se | 4 Homicide determined (Specify) 29a Certifier (Check only (Check only (Specify)) | other- dge, death occur | | date and place, and | Abingdon due to the caus | | tarted |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | Medical | one) 2 Medical Examiner: On the basis of examination and manner stated. | | tion, in my opinic | on, death occurred | | and place, and due to | the cause(s) |
| | Σ | 29b. Signature and title of certifier | | | se number .M.E. | | 29d. Date signed (# November 22, | |
| O O O | | 30. Name and address of person who completed cause of death (Itel | | | | | l | |
| pene | | Zabiullah Ali, M.D. Assistant Medical Examine 31. Date filed (Month. Day Year) 32 Registrar's Signa | | n Street, Ba | Itimore, MD 2 | 1201 | | |
| St Regis | ate trar | 31. Date filed (Month, Pay Year) 2006 32 Registrar's Signa | 1 100 | ALI | | | | |

| | | | Please | State of Ma | | | | • | _ | | |
|--------------------------------|--|---|---|-------------------------|----------------------|---|---|---------------------------------------|-------------------------------|---|--|
| | | • | State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. N2 0 0 6 3 7 5 7 | | | | | | | 37571 | |
| | | ** | Decedent's Name (First, Middle, Last) | | | | | 2. Date of Death Month | Day Year | 3. Time of Death | |
| | Physicia /Medic | | ALMA D. MAKER | | | | 22, 2006 | 7:30p ^M | | | |
| | Examin Funeral Director | | 4a. Facility Name (If not institution, give street and number) | | | 4b. City, Town, or Location of Death | | | 4c. County of Deat | h | |
| | | | 1208 N. BENTALOU ST. | | | BALTIMORE If Under 1 Year If Under 24 Hrs. | | 8. Date of Birth | N/A | | |
| i. | | | | | | | Months Days Hours Min. (Month, Day, Year) 8-31-1929 | | | hplace (State or Foreign nuntry) LAND | |
| | ם | | Usual Residence of Decedent | | | | | | 2) IIAIL | | |
| | ehow | Director | 10a. State 10b. County 10c. City, Town or MD • N/A BALTI | | 10c. City, Town or I | | | | | 10d. Inside City Limits 1 X Yes 2 No | |
| | within 72 hours after death with the Maryland ene. Then "neturel" or flems 23s or 28e-f ehow re Madical Examiner must be multiked at | | 10e. Street and Number | | DALITE | 10f. Zip Code | | | g. Citizen of What Co | | |
| | | 2 | 1208 N. BENTALOU ST. | | | | 21216 | | | | |
| | | by Funerai | 11. Marital Status | 12. Was Decedent 6 | Ever in U.S. 13 | | | | USA 14. Race - Ame | | |
| 9 | | / Fu | 1 Never Married 2 Married | | lo | 1 ☐ Yes 2 ☐ No | Specify: | nican, etc.) | Black, White | BLACK | |
| 21215-0036 | hours urel', | q pa | 3 Widowed 4 Divorced Year or Dates: | | | ** | | | ib. Kind of Business/Industry | | |
| 7 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Integrate it is marked other then "neturel", or temps 23c or 28e-1 ehow eny injury or other treumetic event, Ira Madical Examinat must be millist at once. | Completed | (Specify only highest g | rade completed) | (Giv | Give kind of work done during most of working life. DO NOT use retired) | | | D. Kind of Business/ | b. Naid of business/industry | |
| 212 | | lmo | Elementary/Secondary (0-12) -12- | College (1-4or 5 -0- | | ERSONNEL | | | HECHT DE | PT. STORE | |
| 밀 | | Be | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Name (First, Middle, Mai | | | den Sumame) | | |
| yla | | 2 | EDWARD T. ALLE | ALMA D. SUTTON | | | | | | | |
| Maryland | | | 19a. Informant's Name/Relationship (Type, Print) MARCEL B. MAKER(SON) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1208 N. BENTALOU ST. BALTIMORE, MARYLAND 21216 | | | | | | | | |
| Ġ, | | | | | | | | | | | |
| Baltimore, | Pages ent of nt: If i | | 20a. Method of Disposition 1 Burial 2 Cemation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Date 20c. Location - City or Town, State 12-1-2006 CARRISON FOREST VETERANS OWINGS MILLS MARYLAND | | | | | | | | |
| altii | mit. I partm portei y injui | | 21. Signature of Densey ONATHAN D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. | | | | | | | | |
| Ä | Depar Depar Impor eny ir | | matte | - U. Ac | | | | | | LAND 21217 | |
| Vital Records, P.O. Box 68760, | To the Hospitel or Attending Phyeicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and properties of the funeral director, and be detached for use as the burial-transit or properties of the funeral director, page 2 should be detached for use as the burial-transit. | Completed by Physician/Medical Examiner | 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or learn failure. List only one cause on each line. Immediate a se (Final disease or or difficion resulting in Math) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | |
| | | | d | | | | | 23d. Date of delivery Month Day Year | | | |
| | | | Part II. Other significant conditions | ,···g | | | pacco use contribute to the cause of death? | | | | |
| | | | | | | | | 24a. Was an autopsy performs | prior to | atopsy findings available completion of cause of 2 No | |
| | | Be c | 25. Was case referred to medical examiner? | Hospital: | -1 2FR/0:4-4 | ent 3 DOA Othe | 200 | th (Check only one) | | | |
| | | atlon: To | 1 Inpatient 2 EMOutpatient 3 DOA 4 Nursing Home 512 Hesidence 6 Dotner (Specify) | | | | | | | | |
| ion | | | 1 Matural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No | | | | | | | | |
| Division of | | Certification: | 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) | | | reet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | ıral Route Number, | |
| | | Medical C | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| | | | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) | | | | | | | | |
|) | - > - 0 | | Man I Work Attending Physician D 26534 11/27/06 | | | | | | | | |
| | 5 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 120 Sister Pierre Dr. #105 Towson MD 21204 | | | | | | | | |
| | Sta | | 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature | | | | | | | | |
| | Registr | ar | NOV 2 8 | 2006 1 | 18 1 | neith o | | | | | |

DHMH 17 Rev 1/2001

ORIGINAL

06-08860 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Margaret Mace Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2045 hrs November 20, 2006 Medical Examiner MARGARET R. MACE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore BALTIMORE CITY Harbor Hospital Center If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** 5. Social Security Number 6. Sex Months Days Hours Min. AUG. 3, 1953 Country) MARYLAND 217-58-0850 Director M 2 X F 53 Usual Residence of Decedent 10d. Inside City Limits IOc. City, Town or Location 1 Yes 2 X No LINTHICUM ANNE ARUNDEL MARYLAND or 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygore.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other tranmatic event; the Decired Examiner must be notified at once injury or other tranmatic event, the Decired Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 21090 UNITED STATES 714 WEDEMAN AVE. 14. Race - American Indian, Black, Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 1 Yes WHITE 1 Yes 2 X No specify: Specify: Widowed 4 Divorced If Yes, Give Year \$ Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 OWN HOME 12 HOMEMAKER 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ROSE STANKOVICH Be WILLIAM NOLL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) LINTHICUM, MARYLAND 21090 714 WEDEMAN AVE., CHRIS B. MACE / HUSBAND 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, 1 Burial 2 X Cremation 3 Removal from State NOV. 25, crematory or other place) 2006 CATONSVILLE, MARYLAND METRO CREMATORY, INC. Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses KIRKLEY-RUDDICK 421 CRAIN HWY., FUNERAL S.E., G AL HOME, P.A. GLEN BURNIE, Davie 21061 MD Approximate Interval 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Between Onset and /Medical Death Xcute Bowel Perforation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Cecal Volvulus Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical UNPENDED AMENDED the attending physician led for use as the burial Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. director, 25. Was case referred to medica of Vital Be Other 4 examiner? 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 Inpatient this ို 1 🗸 Yes 2 funeral (After t 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: within 24 hours autor ver.

To the Funeral Director: A! Division 1 V Natural Yes 2 No Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 / Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. November 21, 2006 30. Name and address of person who completed cause of death (Item 23a) 10 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD

Registrar's Signature 31. Date filed (Month, Day, Year)

State Registra

ORIGINAL

| | | | 1 - For State Registrar | State of | Marylan | | | | lealth a | | Mental Hy | giene Reg. N | 2005 | 37573 |
|-------------------|---|------------------|--|------------------------------|---|------------------------|------------------------|--------------------|-----------------------------|-----------------------|---------------------------------|-------------------------|-------------------------------------|---|
| | Fig. 1 | | Decedent's Name (First, Middle, | Last) | | | | | | | 2. Date of De | ath | | 3. Time of Death |
| Ą | Physici /Medic | | Helen El | izabeth | Muelle | er | | | | | Novembe Novembe | Day 20 20 | | 6:45 P M |
| y | Examir | | 4a. Facility Name (If not institution, g | | | | 4b. City | , Town, o | r Location | of Death | THO V CALLY | | County of Deat | |
| A. | | | Rineholt As | sisted Liv | zina | | Ris | sing | Sun | | | Ce | ecil | |
| | Funeral | | | | | last birthday) | II Unde Months | T 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bir (Month, Da | th y, Year) | 9. Birti Co | nplace (State or Foreign untry) |
| | Director | | 388-05-0710 | 1 | 93 | Yrs. | | | | | Aug. 8 | . 191 | L3 Wisc | consin |
| | and | | Usual Residence of Decedent 10a. State 10b. County | | 10c. Cit | y, Town or Lo | cation | | - | | | | | 10d. Inside City Limits |
| | Mary f sho | ō | Marriand Harrian | a | Del | 7) | | | | | | | | 1 XYes 2 No |
| | 28a | Je. | Maryland Harfor | <u> </u> | BeT | Air | 10f. Zi | p Code | | | | 10g. Citi | zen of What Co | untry? |
| | 3a or | <u>a</u> | 600 Squire Lan | e 2C | | | 21 | .014 | | | | USA | | , |
| | be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or itema 23a or 28a-f show event, the Madical Examinar must be notilised at | Funeral Director | 11. Marital Status | 12. Was Decede | | | Was Dece | edent of H | ispanic Ori | igin? (Sp | ecify Yes or No | | 14. Race - Amer | |
| 9 | or its | Ē | 1 ☐ Never Married 2 ☐ Married | Armed Force | | ĺ | | | | | Rican, etc.) | | Black, White | e, etc. |
| 93 | ral', | 1 by | 3 🖫 Widowed 4 ☐ Divorced | If Yes, Give Year or Date | es: | | 1 □ Yes | 21 25. No | Specify: | | | | Specify: Wh | ite |
| 21215-0036 | 72 h 'natu | Completed | 15. Decedent's (Specify only highest | Education grade completed) | | 16a. Dece (Give | kind of wi | ork done | during mos | t of work | ing | 16b. Kir | nd of Business/I | ndustry |
| 121 | of thin | mpi | Elementary/Secondary (0-12) | College (1-4 | or 5+) | life. | DO NOT I | ise retired | 1) | | | | | |
| S | filed v Hygie other t | | 12 17. Father's Name (First, Middle, La | eti | | Homem | aker | | 10 Math | ada Nasa | a (Cina Adalah | | 1 Home | |
| anc | | Be | | | | | | | 18. Mothe | ers Nam | e (First, Middle, | Maiden | Sumame) | |
| Ž | 2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the M | To | Henry (nmn) Ko | pegler | | 10h Malii | | - (C11 | Ann | | | Bruss | | |
| Maryland | s 1 and 2 should F Health and Men Item 27 is marke other traumatic | | Paul H. Muelle: | | | | _ | | | | | | Town, State, Z | . , |
| | of Health item 27 i | | 20a. Method of Disposition | . / 5011 | 20b. P | Place of Dispo | | | | | Date | | land 21 | |
| Ö | 00 | | 1 Burial 2 □ Cremation 3 | | ale | | | | , i | _ | | | | |
| Baltimore, | permil. Pag Department Important: i any injury o | | 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service/Lic | | Du. | Laney \ | Valle | y Me | moria ss of Eacilit | 11_{11} | 29-06_ | Time | nium, M | aryland |
| Ba | permit. Departr imports any inju | | Will IVY | 200 | | _ 1 | 1cCon | as F | unera | 1_Hc | me, P.A | ٠. | _ | |
| | * | | 23a. Part1. Ent or the disease, or or | mplications that cau | se the death | | | | | | | | , Maryl | and 21009 |
| | | | shock, or h allure. List or Immediate Cause (Final | ly one cause on eac | h lime | | | , | | | , , , | | | Interval Between Onset and Death |
| Ė | Physician /Medical | | disease or condition resulting in death) | a | | | | | | | | | | |
| | Examiner | | | Due (d)(or | as a consequence | 1 | 1 0 | . 1 | , | | | | | |
| | | ē | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or | as a consequ | | | Ch I | | | | | | |
| | uted d ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | | | |
| á | exec n an ial-tr | Еха | resulting in death) Last | Due to (or | as a consequ | uence ol): | | | | | | | | |
| 8760, | tate be executed thy sicien and the burial-transit | dical | | d | | | | | | | | | | |
| 68 | tifical ig phy as th | led | _ | | | | | | | | | | | |
| Вох | death certificate be executed e attanding physicien and od for use as the burial-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome | me of pregna | | Ectopic p | | | | | 2 | 3d. Date of deliv | /ery |
| | death | sicie | in the past 12 months? 1 ☐ Yes 2 Ø No | 4☐Pregnan 9☐Unknow | t at time of de | | Other (s) | | | | | | Month | Day Year |
| P.0 | that the de led by the ded detached | hys | 9 Unknown | | | | | | | | | | | |
| | Se F90 | by F | Part II. Other significant conditions | contributing to deat | h but not resi | ulting in the u | nderlying (| cause give | en in Part I. | | 23e. Did to | obacco us | se contribute to | the cause of death? |
| ord | w require been si should I | ted | | | | | | | | | 1 🗆 1 | ′es 2□ | No 3 ☐ Pro | bably 4 Unknown |
| မိ | as be | pie | | | | | | | | | 24a. Was | | 24b. Were aut | opsy lindings available ompletion of cause of |
| of Vital Records, | The transfer at the page | Completed | | | | | | | | | perfo | med? | death? | 2□ No |
| ita | ician: certifica ector, p | Be (| 25. Was case referred to medical examiner? | | | | | | 26. Place | ol Deatl | Check only | | | |
| Ž | Physician: this certific ral director. | ၉ | 1 ☐ Yes 2 Ø No | Hospital: 1 ☐ Inpa | atient 2 🗆 | ER/Outpatier | t 3 🗆 D | Othi | er: 4 □ Nu | rsing Ho | me 5 Hesio | lence 6 | Other (Spec | (y) |
| | | 0 | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of I (Month, | njury Day Year) | 28b. Time of Injury | : | 28c. Injun Work | at k? | | 28d. Describe h | ow injury | occurred | |
| S | 1 0 E E | cati | 2 Accident investigat 3 Suicide 6 Could not | | | | М | 1 🗆 | Yes 2 🔲 | No | | | | |
| Division | or At fter d pirect in by | Certification: | 4 Homicide determine | d 28e. Place of | Injury - At ho etc. <i>(Specif</i>) | ome, farm, str v) | eet, lactor | y, office | | | 281. Location (S City or Tow | street and m, State) | f Number or Rui | al Route Number, |
| | urs a | | | | | | | | | | | | | |
| | To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by the | edicai | 29a. Certifier 1 Certifying (Check only 2 Medical Ex | hy it ian: To the be | s of examinat | wledge, death | occurred estigation | at the tim | ne, date an Dinion, deal | d place, th occurr | and due to the o | cause(s) a | and manner as : place, and due ! | stated. to the cause(s) |
| | thin 2 the mple | Mec | 29b. Signature and the of certifier | and manner | stated. | | | c. License | | _ | | | | |
| | F ₹ 5 8 | | | | | | | | 629 | 506 | | 1 | signed (Month, | ≥ay, 16dl/ |
| | 2 | W | | | | | | | | | | 1 | | |
| , | 20 | 1 | 30. Name and a dross of person wh | o completed cause of | or death (Item | ر کا (Type, | Print) | Av- | Havre | 0- | Come | MA | 21078 | |
| | Sta | te | 31. Date liled (Month, Day, Year) | 32. Regi | istrar's Signa | ture | alle B | 17 6 | A.C | - 00 | UIUCC | 000 | , | |
| (i) in | Registr | | NOV 2 8 2 | 006 | 100 25 | S. S. S. S. | A Barre | | | | | | | |

| | | | For State Registrar | State | of Marylar | • | artment of H rtificate of L | | | | iene g. No. 0 | 5 | 37574 |
|----------------|---|-------------------|--|-------------------------------------|--|------------------------|--|-------------------|----------------|-------------------------------|--------------------------|------------|--|
| | | | 1. Decedent's Name (First, Middle | e, Last) | | | | | | Date of Deatl Month | | Year | 3. Time of Death |
| | Physicia /Medic | | | Mae | Iona | a | McCartne | ey | | | r 21,20 | | 5:55 P M |
| | Examin | | 4a. Facility Name (If not institution | n, give street and nu | ımber) | | 4b. City, Town, or | Location | of Death | | 4c. County o | f Death | |
| | | | Genesis Herita | age Merid | ian Car | e Ctr. | Dunda | | | | | | imore Co. |
| | Funeral | | 5. Social Security Number | 6. Sex 1 ☐ M 2 ☑ F | 7. Age (In yrs. | | If Under 1 Year Months Days | If Under Hours | Min. | Date of Birth (Month, Day, | | 9. Birthp | place (State or Foreign ntry) |
| | Director | | 213-16-9664 | I I W STATE | 100 | Yrs. | | | Ma | y 8, 1 | .906 | Ohi | .0 |
| | and * | 1 | Usual Residence of Decedent 10a, State 10b. County | | 10c. C | ity, Town or Lo | ecation | | | | | 1 | 10d. Inside City Limits |
| | Maryl f eho | ō | | | | | | | | 7 71 | | | 1 ☐ Yes 2 ➡No |
| | the 1 | rect | Maryland Ba | altimore | | | 10f. Zip Code | | Du | ndalk 10 | Og. Citizen of W | nat Cour | ntry? |
| | 3a or | <u> </u> | 7652 Old Bat | tle Grow | bood | | | 21222 | | | United | St: | ates |
| | death me 2: | Funeral Director | 11. Marital Status | 12. Was Dec | edent Ever in U | J.S. 13. | Was Decedent of Hi If Yes, specify Cuba | | | Yes or No- | 14. Race | - Americ | can Indian, |
| ထ | or Ital | 교 | 1 ☐ Never Married 2 ☐ Marr | ied Armed F | 2 ☑ No | | | | | ın, etc.) | | , White, | etc. |
| 8 | rel', c | d by | 3 ☑ Widowed 4 ☐ Divorced | If Yes, G Year or I | | | 1 ☐ Yes 2 ☑ No | Specify | · | | Specify: | V | White |
| 21215-0036 | within 72 hours effer death with the Maryland ene. than "naturel", or Itame 28a or 28e-f ehow the Medical Examinar mant be notified at | Completed | 15. Deceden (Specify only highe | t's Education st grade completed |) | (Give | dent's Usual Occupa | during mos | st of working | , | 16b. Kind of Bus | iness/In | dustry |
| 2 | Athin ne. | mp | Elementary/Secondary (0-12) | College | (1-4or 5+) | | DO NOT use retired | 0 | | | | | |
| 2 | filed w Hygie other t | | 6 Years 17. Father's Name (First, Middle, | (act) | | Sec | cretary | 18 Moth | per's Name (Fi | | Dundalk Maiden Sumame | | rist |
| anc | be fi | Be | | Last | | | | TO. INIOTH | | ra Inm | | / | |
| ž | should nd Men marke | 입 | John Lowery 19a. Informant's Name/Relations | hin (Time Print) | | 10h Maili | ng Address (Street a | and Numb | | | | tate Zir | Codel |
| Maryland | d 2 s th an 7 le r treur | | Mr. Carl McEll | | Son) | | 7 Old Bati | | | | • | | 21222 |
| d) | ss 1 and 2 should be filed within 72 hours efter death with the Marylan of Heelih and Mental Hygiene Item 27 le marked other than "naturel", or Itame 23a or 28e-1 ehow r other treumatic avent, Ire Medical Evanti ar mast teanotified at | | 20a. Method of Disposition | 1020 / | 20b. | Place of Dispo | sition (Name of | 1 | Date | _ | 20c. Location - C | | own, State |
| Baltimore, | permit. Pages 1 Department of H Important: If Ite any Injury or ot once. | 1 | 1 Burial 2 ☐ Cremation 4 ☐ Dopation 5 ☐ Other (S | | i State 🥒 | 7 // | matory or other plac age Mem. 1 | | 11/25/ | 2006 | Dol+i | nio re | e, Maryland |
| ₫ | artme artme ortan Injur | | 21. Signature of America Service | _ | MA | 1/1/2 | 2. Name and Addres | s of Facil | lity | | | | |
| Ba | Depa Impo any I | | Made | 11/19 | 126 | | ouda-Ruck | Fune | eral Ho | | | | |
| | - 0 - | | 23a. Part 1. Enter the disease, or | complications that | caused the dea | | 922 Wise er the mode of dying | | | | | | 222 Approximate |
| | Pnysician | | shock, or heart failure. List Immediate Cause (Final | only one cause on | each line. | Till | HEA | 1-0- | 6 | 1100 | Į. | | Interval Between Onset and Death |
| | /Medical | | disease or condition resulting in death) | a. Due to | (or as a conse | quence of): | MEA | rk/ | 1 25 | 16110 | | | |
| | Examiner | | WOODS AND THE RESERVE | 145 | IPER. | FEN | S10 AD | | | | | | |
| | | ner | Sequentially list conditions. if any, leading to immediate cause. Enter Underlying | Due to | (or as a conse | quence of): | | | | | | | |
| V | ecute ind trans | Examine | Cause (Disease or injury that initiated events resulting in death) Last | c | PHO | EX 71 | A | | | | | | |
| 8760, | ate be executed hysiclen and the burial-transit | û | resulting in death, East | Due to | (or as a conse | quence or): | | | | | | | |
| 87 | physic | Physician/Medical | | d | | | | | | | | | |
| 9 X | death certificate e attending phys id for use as the | /Me | IF FEMALE: | 23c. If yes, or | utcome of pregr | nancv | | | | | 23d. Date | of doline | an. |
| Вох | atten for u | cian | 23b. Was decedent pregnant in the past 12 months? | 1 Live | birth 2 ☐ Fet | aldeath 3[| Ectopic pregnancy Other (specify) | | | | Mont | | Day Year |
| o. | that the de ted by the a detached | ysi | 1 | 9□ Unk | | | | | | | | | |
| 0 | requires that een signed b hould be deta | by Pi | Part II. Other significant condition | ons contributing to | death but not re | sulting in the u | nderlying cause give | en in Part | I. | 23e. Did tob | acco use contrit | oute to th | he cause of death? |
| rds | w requires been sign should be | | | | | | | | | 1 ☐ Ye | s 2 No | 3 🗌 Prob | pably 4 Dunknown |
| Vital Records, | > .0 0 | ompieted | | | | | | | | 24a. Was ar | 24b_W | ere auto | ppsy findings available impletion of cause of |
| æ | e h age | E | | | | | | | | autops perform | 1ed? / de | eath? | 2DNo |
| ital | ilclen: T certificet rector, pa | Bec | 25. Was case referred to medica examiner? | 1 | | | | 26. Plac | e of Death (Ci | | Y | | |
| of < | d is | 2 | 1 Yes 25 No | Hospital: 1 | Inpatient 2 | ER/Outpatie | | 4 1 1 | ursing Home | 5 🗆 Reside | nce 6 🗆 Other | (Specif | у) |
| | | ü. | 27. Mann Death 1 Death 5 □ Pendir | | of Injury nth, Day Year) | 28b. Time o | Worl | | | Describe ho | w injury occurre | d | |
| sio | Attending r death. ector: Afte by the fune | cati | 2 Accident investi 3 ☐ Suicide 6 ☐ Could | not be | | | | Yes 2 □ | | 1 | | | 1.00 |
| Division | l or Atten after deat Director: | Certification: | 4 Homicide determ | ained 289. Place | e of Injury - At I ding, etc. <i>(Spe</i> c | nome, farm, st ify) | reet, factory, office | | 281. | City or Town | | or Hura | al Route Number, |
| | Hoepital | | 29a. Certifier 1 Certifyin | ng Physician: To th | ne heet of my kn | owledge deal | h occurred at the tim | ne date a | nd place, and | due to the ca | use(s) and man | ner as s | tated |
| | To the Hoepital or At within 24 hours after or to the Funeral Directomplately filled in by | edicai | | Examiner: On the | | | | | | | | | |
| | To the within 2 To the complet | Me | 29b. Signature and title of certifie | | | | 29c. License | e number | | 25 | d. Date signed | (Month, | Day, Year) |
| } | r > r 0 | | Sain and. | 1, 11 | 1000 | MM | 100 | 271 | 88 | | 11/2 | 1/6 |)(|
| | ^ | | 30. Name and address of person | who completed car | use of death (Ite | om 2 a) (Type, | Print) | 1 | | | | 1 | b |
| | 8 | | Savinda | 12 Jul | R 2 | Mar | they Il | 40 | DUN | Still | MD | 2 | 1222 |
| | Sta | | 31. Date filed (Month, Day, Year, | | Registrar's Sign | nature | | | | | | | |
| 1 | Registi | ar | NOV 2 | 8 2006 | Carlotte o | K B | MAN B | | | | | | |

DHMH 17 Rev 1/2001

ORIGINAL

| | | 1 | State of Maryland / Department of Health and 1- State Amend #23e,28e,28f, perilE, 8863, I/18 Certificate of Death | Mental Hygi | ene 006 37575 |
|----------------------------|--|---------------|--|---|--|
| | Physici /Medic | | 1. Decedent's Name (First, Middle, Last) Brian Mathews | 2. Date of Death Month NOVEMBE | Day Year 3. Time of Death |
|) | Examir Funeral | er | University of Maryland Medical Center Bultimore 5. Social Security Number 6. Bex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | 8. Date of Birth | 4c. County of Death 9. Birthplace (State or Foreign |
| | Director | | 213.17.4563 Usual Residence of Decedent 1 X M 2 F | Month, Day, | |
| | aryland ehow | _ | 10a. State 10b. County 10c. City, Town or Location | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| | r 28a-f | Director | Maryland Howard Columbia 10e. Street and Number 10f. Zip Code | 10 | g. Citizen of What Country? |
| | ath with | ralD | 9027 Shinleaf Court 21045 | | U.S.A. |
| 9036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. By injury or other traumatic event, I'm Medical Evan Larman ke rolling at ance. | by Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. Amped Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer It Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer It Yes, Give Year or Dates: | Specify Yes or No- to Rican, etc.) | 14. Race - American Indian, Bfack, White, etc. Specify: White |
| 21215-0036 | within 72 ho ene. then "netu | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) Corporal | rking | 6b. Kind of Business/Industry US Marine Corps |
| nd 2 | be filed tal Hygi d other event, I | Be | 17. Father's Name (First, Middle, Last) 18. Mother's Nat | me (First, Middle, M | aiden Sumame) |
| Maryland | should be nd Mental s marked o umatic eve | ၉ | William R. "Bill" Mathews 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Ri</i> | | Trudy" Childs City or Town, State, Zip Code) |
| | end 2: | | Mr. William Mathews Father, 9027 Shinleaf Court Colur | mbia, Marylan | d 21045 |
| nore | Pages 1 nent of H int: if ite iry or otl | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) / | Date 2 2/06/2006 | oc. Location - City or Town, State Arlington, Virginia |
| Baltimore, | permit. I Departm Importar eny injur | | 21. Stratul of Fugeral Service Licenses 22. Name and Address of Facility Slack Funeral Hom | | Attractor, virginia |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiar shock, or heart failure. List only one cause on each line. | - Pike Ellicott | City, VD 21043 Approximate fnterval Between |
| | Physician /Medical | | Informediate Cause (Finaf disease or condition a. Traumatic Brain Tayung a. Traumatic Brain Tayung | (| Onset and Death |
| | Examiner | | Due to (or as a consequence of): Sequentially list conditions b. | , V | CAL STANII |
| | uted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | C. DET ME | , |
| 8760, | rate be executed hysicien and the burial-transit | Ical Exa | | Aton Reports Brief | |
| 687 | rtificate ng phys as the | | | | |
| P.O. Box 6 | Attending Prysicien: The law requires that the death certificate be executed refeath. refeath. sctor: Atter this certificate hes been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Med | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) | | 23d. Date of delivery Month Day Year |
| ords, P | w requires that been signed b should be deta | ۵ | Part II. Other significant conditions continuously to beautiful flor resulting III the underlying cause given in Part I. | | acco use contribute to the cause of death? |
| Division of Vital Records, | n: The law r icete hes be r. page 2 sh | Completed | | 24a. Was an autopsy perform | 24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No |
| Z Z | ysiciar is certif directo | To Be | examiner? | ath <i>(Check only on</i> e Home 5□ Residen | ce 6 ☐Other (Specify) |
| 0 uc | ling Ph I. After th funeral | lon; | 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 20 Vaccident investigation (// 23 / / 2 1 Yes 2 No | 28d. Describe how | |
| É | i di di | ertification; | 2 Accident investigation 3 Suicide 4 Homicide Could not be determined Suicide Homicide Could not be building, etc. (Specify) Could not be building, etc. (Sp | 28f. Location City City or Town, | set and Jumber of Rural Rout Number, State) Rt. 175 @ Rt. 108 |
| | To the Hoepital within 24 hours a To the Funeral Completely filled | edlcai C | | e, and due to the cau urred at the time, dat | use(s) and manner is stated. e and place, and due to the cause(s) |
| | To the within 2 To the comple | Med | 29b. Ignature and title of cestifier 29c. License number (| 296 | d. Date signed (Month, Day, Year) |
| | 10. | | MD 34030 | N | Nember 24, 2006 |
| | 17 | | 30 Name of address of person who completed cause of death (flem 23a) (Type, Print) Teverny Pumplin 22 South Greene Street | Balk | MD 21201 |
| | Sta Registr | | Jeveny Pamplin 22 South Green Street 31. Date filed (Month, Day, Year) NOV 2 8 2006 Registrar's Signature | | , |

| | | - | 1 - For State Registrar | State of | Marylan | | | of Hea | | Mental Hy | giene Reg. No2 () (| 06 | 37576 |
|----------------|---|---------------------|---|--|--|---|-------------------------------------|--|--|---|---|------------------------------|--|
| | Physici /Medic | an | 1. Decedent's Name (First, Midd Richard | Peter | | M | ack | | | 2. Date of De Month | 25 2 | Year OC (| 3. Time of Death 5:20 PM M |
| | Examin | er | | e Adventist | Hospi | | 4b. City, | Roc | ation of Deatle | <u> </u> | | ontg | omery |
| | Funeral Director | | 5. Social Security Number 075-05-6320 Usual Residence of Decedent | 6. Sex 7. 1 ☑ M 2 ☐ F | Age (In yrs. I | Yrs. | Months | | ours Min. | (Month, Da | y, Year) 1, 1917 | | lace (State or Foreign try) ew York |
| | a-f ehow | ctor | 10a. State 10b. County Maryland Me | ontgomery | 10c. City | y, Town or Lo | cation | Pot | tomac | | | 11 | 0d. Inside City Limits 1 ☐ Yes 2 🌠 No |
| 9036 | be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural", or Itame 23a or 28a-f ehow avent, the Medical Examinar must be Lydfiled at | by Funeral Director | 10e. Street and Number 12235 11. Marital Status 1 Never Married 2 Marital Status 3 Widowed 4 Divorces | If Yes, Give | ent Ever in U. es? No | 1 | Vas Deced | ent of Hispa ify Cuban, M | 20854 nic Origin? (S fexican, Puerl pecity: | pecify Yes or No o Rican, etc.) | | ted - Americ k, White, | States an Indian, |
| 21215-0036 | d within 72 ho giene. Ir than "natu the Medical | Completed | | nt's Education est grade completed) College (1-4 | or 5+) | (Give | kind of wor DO NOT us | l Occupation k done durin e retired) Contra | ig most of wo | rking | 16b. Kind of Bu | | Industry |
| Maryland 3 | 2 should be filed withir and Mental Hygiene. Is marked other than eumatic avent, the Ms | To Be C | 17. Father's Name (First, Middle, | Peter Ma | ck | | | | | Mary J | Maiden Sumame ane Klaj | bor | |
| Baltimore, Mar | permit. Pages 1 end 2 should Department of Health and Mer Important: If Item 27 is marke any injury or other treumatic <u>QDG</u> . | | 19a. Informant's Name/Relation Loretta M. M. 20a. Method of Disposition □ Burial 2 □ Cremation 4 □ Donation 5 Ø Other (21. Signature of Fafferal Service | ack/ Wife 3 □Removal from St Specify) Entombm | ate a | 12 Place of Dispo emetery, crei Gate o Maus | 235 Sustion (Name of Head of Soleur | aint of therplace) ven | James I | Road Pot Date ember 2006 | 20c. Location - 6 | ryla City or To | nd 20854 |
| 68760, | death certificate be executed a attending physicien and a dor use as the buriat-transit | ical Examiner | 23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fract, and representations. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Palson Due to (or c. | MOO3 used the death th line. A M C I I r as a consequence as a consequenc | n. Do not ent | | | | and 2085 c or respiratory a | | C | Approximate Interval Between Onset and Death |
| Box | that the death certificate bed by tha attending physic detached for use as the b | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | h 2∏Feta nt at time of d | Ideath 3 | Ectopic produced Other (sp. | | | | 23d. Date Mor | e ol delive | ny Day Year |
| Records, P.O. | requires been sign should be | ۵ | Part II. Other significant condit | ions contributing to dea | th but not res | ulting in the u | nderlying c | ause given in | Part I. | | Yes 2□No | 3 🗌 Prob | ably 4 SUnknown |
| al Rec | icien: The law certificate has ector, page 2 (| e Completed | 25. Was case relerred to medic. | | | | | | St 4 D | auto perfo 1 ☐ Yes | property of department of the property of the | rior to cor eath? | psy findings available inpletion of cause of |
| ion of Vital | iling Phys | To B | examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident inves | Hospital: 1 Anni 28a. Date of (Month, | | ER/Outpatier 28b. Time o Injury | | Other: 8c. Injury at Work? | | T | dence 6 Othe | | 0 |
| Division | P T T S | Certification: | 4 🗆 Hornicida | mined 288. Place of building | f Injury - At ho g, etc. <i>(Specif</i> | y) | | | | City or To | | | |
| | To the Hospital within 24 hours of To the Funeral completely filled | Medicai | (Check only 2 Medica one) | ing Physician: To the b I Examiner: On the bas and manne | is of examina | wledge, deat tion and/or in | vestigation | in my opinio | on, death occi | e, and due to the urred at the time, | date and place, a | ind due to | the cause(s) |
| | 5 × √ √ | 2 | 29b. Signature and title of centific | FM. | MD | | | DOO 6 | 4029 | 7 | 29d. Date signed | 25 | |
| | 121 | | 30. Name and address of person Brandon Fal | who completed cause | A A | i Ca (Type, | Print) | r D | rive | Rocki | | MD | |
| 72. | Sta Regist | | 31. Date filed (Month, Day, Yea. | | istrar's Signa | ture | post | 9 | | | , | | |

| | | 1 | For State Registrar | State o | f Marylan | | artmen tificate | | | | Re | g. No: | 06 | 37577 |
|----------------------------|--|---------------------|---|---|---|----------------------------------|--|--------------------------|---|------------------------------|---------------------------------|---------------|------------------------------------|--|
| | Physicia | an i | 1. Decedent's Name (First, Middle Harry W. Mohr | | | | | | | 2. Date Mor | of Death 19 , | 2006 | Year | 3. Time of Death |
| | /Medic Examin | | 4a. Facility Name (If not institution G.B.M.C. | | mber) | | 4b. City, | Town, or | Location of Dea | | | 4c. Count | |) |
| A | Funeral Director | | 5. Social Security Number 218-03-5002 | 6. Sex XXM 2□ F | 7. Age (In yrs. 90 | ast birthday) Yrs. | If Under Months | 1 Year Days | If Under 24 Hr Hours Mir | s. 8. Date n. Jul | of Birth oth, Day. y 29, | 1916 | 9. Birth Con Mar | pplace (State or Foreign intry) Yland |
| | Aaryland f show | or | Usual Residence of Decedent 10a. State 10b. County MD Ra1+ | imore | | y, Town or Lo ldwin | cation | | | | | | | 10d. Inside City Limits |
| | with the h a or 28a-i be notifi | Direct | 10e. Street and Number 4907 Carrol1 | | | | 10f. Zip | Code 013 | | | | g. Citizen of | | untry? |
| 336 | ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other then "natural", or Items 23s or 28s-f show atto event, "he Mulical Exam, ar must be notified at | by Funeral Director | 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced | 12. Was Dece Armed For | 2 (Z No ve | 1 | | dent of His | spanic Origin? (n, Mexican, Pue Specify: | (Specify Ye erto Rican, e | s or No- etc.) | Bla | ce - Amer ick, White fy: Whi | · |
| Maryland 21215-0036 | within 72 hou ene. then "natura | Completed | 15. Deceden (Specify only highe: Elementary/Secondary (0-12) 3rd Grade | t's Education st grade completed) Coflege (| 1-4or 5+) | | dent's Usua kind of wo DO NOT us | rk done d se retired) | tion uring most of w | vorking | | 6b. Kind of E | | |
| Jand 2 | 2 should be filed within and Mental Hygiene. Is marked other then eumatic event, The M | To Be Co | 17. Father's Name (First, Middle, Charles Mohr | Last) | | | | | 18. Mother's N | | Middle, M | - | | |
| Mar | nd 2 should have he lith and he 27 is ma | | 19a. Informant's Name/Relations Harry W. Mohr | | n | | | | nd Number or I Court | | | | n, State, Z 013 | ip Code) |
| lore, | Pages 1 ar | | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation | 3 □Removal from | State 20b. F | Place of Dispo cemetery, crea | sition (Nar matory or o | ne of ther place |) | Date | 2 | 0c. Location | - City or | Town, State |
| Baltimore, | permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 is marke eny Injury or other treumatic. <u>once.</u> | | 4 Donation 5 Other (S | | Uan | | 2. Name ar | nd Addres | s of Facility | Char1 | es S | Zeile | r & S | Son, Inc. |
| | Physician | | 23a. Part1. Enter the disease, or shock, or heart failure. Light | omplications that only one cause on | each line. | h. Do not en | er the mod | le of dying | ern Ave | iac or respir | atory arre | st, | MD | Approximate Interval Between Onset and Death |
| | /Medical Examiner | | disease or condition resulting in death) | Due to | on 9 to | uence of): | rara | 1/2/ | 1672 | rct | 702 | | | 1 Wtck |
| | cuted and ransit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. Due to | (or as a conseq | uence of): | | - 70 | | | , | | | |
| 8760, | ate be executed hysician and the burial-transit | cal | resulting in death) Last | d | (or as a conseq | juence of): | | | | | | | | |
| P.O. Box 6 | ne death certifica the attending ph thed for use as th | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 Live | tcome of pregna birth 2 ☐ Feta nant at time of d own | Il death 3 | ∃Ectopic p ∃ Other (sp | | | | | | ate of deli | ivery Day Year |
| | w requires that the deben signed by the should be detached | þ | Part II. Other significant conditi | ons contributing to d | | | inderlying o | ause give | n in Part f. | 23 | le. Did tob | > | ntribute to | the cause of death? |
| Division of Vital Records, | Physician: The law requires that the this certificate has been signed by the tall director, page 2 should be detached. | Completed | | , | | | | | | - | a. Was ar autopsy perform | / | . Were au prior to death? | topsy findings available completion of cause of |
| Vita | sician: certifica rector. | Be | 25. Was case referred to medica examiner? | Hospital | | 150/0 · | - 4 - | Othe | 26. Place of D | | | / | h (C | 4.1 |
| ion of | ling After fune | ation; To | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendii 2 Accident investi | 28a. Date (Mor | | 28b. Time of finjury | | 28c. Injury Work | | | | w injury occu | | спу) |
| Divis | To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the | Certification: | 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ | nined 200. Flatt | e of Injury - At h ling, etc. (Speci | ome, farm, st | reet, factor | y, office | | | cation (Str y or Town | | nber or Ru | ral Route Number, |
| | To the Hospital or within 24 hours after To the Funeret Dir. completely filled in I | edicai | | ng Physician: To the Examiner: On the band man | | | | | | | | | | |
| | To th Within To th compl | Me | 29b. Signature and title of certifie | | MA | | 29 | c. License | | . 6 | | | | h, Day, Year) |
| f | 107 | | 30. Name and address of person | who completed cau | se of death (Iter | m 23a) (Type | Print) | -/- | 5315 | Cook | | 1110 | | 21030 |
| 25 | Sta | ate | JUh SIM 31. Date filed (Month, Day, Year | | 5-4 Registrar's Sign | | ** * | 4dh | 1 Kd | UCF | cys | VIINE | 70 4 | -1030 |
| 40 | Regist | | NOV 2 8 | 3 2006 1 | ALARA A | b. Do | and s | - | | | | | | |

DHMH 17 Rev 1/2001

| | | | 1 For | State of Marylan | | | nd Mental Hyg | giene | 27572 |
|-------------------|---|---------------------|--|---|---|---|--|--|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | | Certific | ate of Death | 2. Date of Dea | Reg. No. UUU | 3. Time of Death |
| ę | Physici /Medic | | Esther Louise | Nutt | | | Month // - 2 | 11-2006 | 6:00PM |
| 1 | Examin | | 4a. Facility Name (If not institution, give s | treet and number) | 4b. C | ity. Town, or Location of | | 4c. County of Dea | ath |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. I | Mont | der 1 Year If Under 2 hs Days Hours | | 9. Bi | rthplace (State or Foreign |
| | Director | | J35-82-16-70 Usual Residence of Decedent | M 2 X F 53 | Yrs. | | 4-6- | 1953 | VA. |
| | hours after death with the Maryland turel', or Iteme 23a or 28e-1 ehow al Examinational be notified at | ō | 10a. State 10b. County | 10c. City | y, Town or Location | | | | 10d. Inside City Limits 1 ★ es 2 No |
| | h the N or 28a-f | by Funeral Director | 10e. Street and Number | Λ | ith more | Zip Code | 1 | 10g. Citizen of What C | |
| | e 23a c | eral D | 3227 Dudley | Wenue 2. Was Decedent Ever in U. | S 12 Was De | 21213 ecedent of Hispanic Orig | in? (Specify Ves or No. | USA 14. Race - Am | oroza Indian |
| ဖွ | after de or Item maner | Fun | 11. Marital Status 1 Never Married 2 Married | Was Decedent Ever in U. Armed Forces? □ Yes 2 No If Yes, Give | If Yes, s | specify Cuban, Mexican, | Puerto Rican, etc.) | Black, Whi | |
| 21215-0036 | hours sture!, | ed by | 3 ☐ Widowed 4 ☐ Divorced | Year or Dates: | 16a. Decedent's L | | | 16b. Kind of Business | S/Industry |
| 215 | within 72 ene. then "na | Completed | (Specify only highest grade | completed) College (1-4or 5+) | (Give kind of | work done during most Tuse (mired) | of working | Fal | |
| | Hygie Othert | Be Co | 17. Father's Name (First, Middle, Last) | _ | Machine | 18. Mather | 's Name (First, Midele, | Maiden Sumame) | ory |
| Maryland | s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 Ie marked other then "naturel", or Items 23e or 28e-1 ehow other traumatic event, the Medical Francian count for coulding an | To B | Wellby Smith, | Sri | | Au | breyNa | e Hodge | Smith |
| Mar | nd 2 should alth and 27 le m | 1 | nforman's Name/Relationship by | tus band | 19b. Mailine Addr | ess (Street and Wumber | Bull Royle Number | r, City or Town, State, e, MD 2 | Zip Code) 1213 |
| ore, | Pages 1 a nent of Hea ant: If Item ury or othe | | 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re | 20b. P | lace of Disposition (| Name of or other place) | Date | 20c. Location - City | |
| Baltimore | | | 4 □Donation 5 □Other (Specify) 21. Signa of Funeral Service License | • () | t. Verno | and Address of Eacility | 125/06 | Whitest | one, VA |
| Ba | permit. Depart Import eny Inj | | Dery O. U | Jaddy | 10ex | Mary Ba | II Pd., Lanc | aster, VA | 22503 |
| | | | 23a. Part1. Enter the disease, or complications, or heart failure. List only on immediate Cause (Final | cations that caused the death e cause on each line. | h. Do not enter the n | node of dying, such as o | ardiac or respiratory arr | est, | Approximate Interval between Onset and Death |
|) | /Medical | | disease or condition resulting in death) | Due to (or as a consequence | uerice of): | PUST | WIND | | HAMADUH |
| | Examiner | er | Sequentially list conditions, if any, leading to immediate | Due to (or as a consequ | uence of): | | | | |
| 1 | ocuted nd transit | Examiner | Cause (Disease or injury that initiated events | | | | | | |
| ,092 | ate be executed hysicien and he burial-transit | calEx | resulting in death) Last | Due to (or as a consequ | uence of): | | | | |
| 89 | rtificate ng phys s as the | | IF FEMALE: | | | | | | |
| Вох | es that the death certifica igned by the attending ph be detached for use as th | by Physician/Med | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo | 3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de | I death 3 □Ectopi | c pregnancy (specify) | | 23d. Date of de Month | elivery Day Year |
| P.0. | at the d by the stached | Physi | 9 ☐ Unknown | 9□ Unknown | | | | | |
| | The law requires that the tto has been signed by the bage 2 should be detache | | Part II. Other significant conditions con | tributing to death but not result (1) | - | ig cause given in Part I. | | bacco use contribute t 'es 2□No 3□P | robably 4 // known |
| of Vital Records, | aw require as been sig 2 should b | Completed | | | | | 24a. Was a autops | | utopsy findings available completion of cause of |
| al R | t: The icate har. | | / | | | | perfór | med? death? | s 2 No |
| Z: | Physician: r this certific ral director, | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No | ospital: 1 ☐ Inpatient 2 ☐ | ER/Outpatient 3 | Other | of Death Check only o | | ecify) |
| o u | ling Ph I. After th uneral | | 27. Manne of Death 1 ☑Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe h | ow injury occurred | |
| Division | Attending It death. sctor: After by the fune | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At ho | ome, farm, street, fac | 1 ☐ Yes 2 ☐ N tory, office | 28f. Location (S | treet and Number or F | lural Route Number, |
| ā | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | | 4 Horricide | building, etc. (Specify | | | City or Tow | | |
| | e Hosp 24 ho e Fune letely fi | edical | 29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin | ician: To the best of my knower: On the basis of examination and manner stated. | wledge, death occur tion and/or investigat | red at the time, date and tion, in my opinion, death | place, and due to the c n occurred at the time, d | ause(s) and manner a late and place, and du | s stated. e to the cause(s) |
| | To the within 2 To the comple | Me | 29b. Signature and title of certifier | 2 | | 29c. License number | 40 | 29d. Date signed (Mon | th, Day, Year) |
| • | 1 | | 30. Jump and address of person who co | mper cause of leath (Item | 23A) (Tvue, Print) | 1 1301 | 2 11 | 11/22/ | 116 |
| | 9 | | DOMM WITTH | 10/24311 4 | (MNOF IM | and Rol o | BUHO, N | 11/2/2 | 18 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 32, Registrar's Signa | ture | , | / | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 19, 2006 **Physician** Norfolk Virginia Belle /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 1204 Jewelweed Path Pasadena 8. Date of Birth (Month, Day, Year) Dec. 5,1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Under 1 Year | If Under 24 Hrs. **Funeral** Days 88 1 □ M 2 📉 F 217-07-1759 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show iny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a State 10h. County Director Pasadena MDAnne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21122 U.S.A. 2944 Beaverbrook Court Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Horton Annie Hill 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daughter Mrs. Rosalie F. Jenkins/ 2944 Beaverbrook Court Pasadena, MD 21122 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury of once. 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem.Park 2006 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01411 Second Avenue SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Life, Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by ti 23e. Did tobacco use contribute to the cause of death? Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? certificate 1□ Yes 2 No Be

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 26. Place of Death (Check only one)

Other: 4 □ Nursing Home 5 □ Residence 6 ☒Other (Specify Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier

32. Registrar's Signature

State Registrar

Certification: To

Medical

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

within 24 hours after death To the Funeral Director:

ORIGINAL

D-40521

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Day

Year

11:00Pm

9. Birthplace (State or Foreign Country)

White

MD

10d. Inside City Limits

1 ☐ Yes 2 No

Month

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 29c. License number

November 21, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 Kospital Brize Suite PR Och Burne, MD 21061 Suite 208

| giene | 0 | 0 | pre . | 0 " | 7 |
|----------|---|---|-------|-----|---|
| n = 11 / | | | 3 | . 1 | Ì |

| 3 | 7 | 5 | 8 | 1 |
|---|-----|--------|--------|---|
| 0 | - 1 | \sim | \sim | ~ |

| Physician |
|-----------|
| /Medical |
| Examiner |
| |

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

8:45 a.m.

NOVEMBER 18, 2006

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

GERTRUDE NOWAK

St Regist

| | For State of Maryland | | rtificate of L | | Reg. N | 2006 | 37580 |
|-----------------------------|--|-----------------------------|---|---|---|-------------------------------------|---------------------------------------|
| | 1. Decedent's Name (First, Middle, Last) | | | | Date of Death Month | ay Year | 3. Time of Death |
| n il | Gertrude | J. Nov | vak | | November | | |
| r | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or | Location of Death | | c. County of Dea | |
| | Stella Maris Hospice Ctr. | | Timoni | | D. D. to of Birth | | nore Co. |
| | 5. Social Security Number 6. Sex 7. Age (In yrs. la | ast birthday) Yrs. | Months Days | Hours Min. | 8. Date of Birth (Month, Day, Yea | (r) Co | thplace (State or Foreign ountry) |
| | 215-18-5781 84 | | | | Sept. 22, | 1922 Ma | aryland |
| | Usual Residence of Decedent 10a. State 10b. County 10c. City | , Town or Lo | ocation | | | | 10d. Inside City Limits |
| ō | Maryland Baltimore | | | | Dundalk | | 1 □ Yes 2 ☑ No |
| rec | 10e. Street and Number | | 10f. Zip Code | | | Citizen of What Co | ountry? |
| Funeral Director | 1312 Delvale Avenue | | | 21222 | Ur | ited Sta | ates |
| Jers | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? | S. 13. | Was Decedent of Hi If Yes, specify Cuba | spanic Origin? (Spen | ecify Yes or No- | 14. Race - Ame Black, Whi | |
| | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give | | 1 ☐ Yes 28 No | | , | Specify: | , |
| ģ | 3 ☑ Widowed 4 ☐ Divorced Year or Dates: | | | | Lant | | White |
| Completed | 15. Decedent's Education (Specify only highest grade completed) | (Give | edent's Usual Occupa e kind of work done o DO NOT use retired | luring most of work | | Kind of Business | rindustry |
| шb | Elementary/Secondary (0-12) College (1-4or 5+) | | | <i>'</i> | | Oran II | ~m.a |
| | 12 Years 17. Father's Name (First, Middle, Last) | HC | ousewife | 18. Mother's Name | e (First, Middle, Maio | Own Ho | лпе |
| Be | John Wojeik | | | | Agnes Pa | alasik | |
| ို | 19a. Informant's Name/Relationship (Type. Print) | 19b. Mail | ina Address (Street | and Number or Run | al Route Number, Cit | - | Zip Code) |
| | Mr. Paul Nowak (Son) | 1 | _ | | Fawn Gro | | 17321 |
| | 20a. Method of Disposition 20b. P | lace of Disp | osition (Name of ematory or other place | | Date 20c | Location - City o | r Town, State |
| | Burial 2 Cremation 3 Removal from State | , | sary Ceme | í i | 22/2006 | Baltimo | re, Maryland |
| | 21. Signature of Juneral Service Licensee | 1 2 | 22 Name and Addres | s of Facility | | | |
| | heller field | 7 | uda-Ruck . 922 Wise A | runeral E Ave. Dun | ome of Du dalk, Mar | yland 2 | 1222 |
| | 23a. Pant. Enter the disease, or complications that consecutive shock, or heart failure. List only one cause on each line. | | | | | | Approximate Interval Between |
| | Immediate Cause (Final | m | | | | | Onset and Death |
| | disease or condition resulting in death) a. COLON CANCE Due to (or as a conseq | | | | | | |
| | Conventionly list conditions | | | | | | |
| ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events | uence of): | | | | | |
| ami | that initiated events resulting in death) Last Due to (or as a conseq | | | | | | |
| Û | Due to (or as a conseq | derice or). | | | | | |
| edical Examiner | d | | | | | | |
| /Me | IF FEMALE: 23c. If yes, outcome pf pregna | ancy | | | | 23d. Date of de | elivery |
| Be Completed by Physician/M | 23b. Was decedent pregnant in the past 12 nonths? 1 ☐ Yes 2 2 No ☐ University 1 ☐ Live birth 2 ☐ Feta | death 3 | ☐ Ectopic pregnancy ☐ Other (specify) | <u> </u> | | Month | Day Year |
| ysid | 1 ☐ Yes 2 Ma No 9 ☐ Unknown | | | - | | | |
| / Ph | Part II. Other significant conditions contributing to death but not res | ulting in the | underlying cause giv | en in Part I. | 23e. Did tobac | co use contribute | to the cause of death? |
| q p | | | | | 1 ☐ Yes | 2 No 3 1 | Probably 4X Unknown |
| lete | | | | | 24a. Was an | 24b. Were | autopsy findings available |
| gmo | | | | | autopsy performed 1 Yes 2 | | o completion of cause of es 2 □ No |
| S | 25. Was case referred to medical | | | 26. Place of Dea | 1 Yes 2X th (Check only one) | NO TEN | |
| o Be | examiner? 1 ☐ Yes 2 🛣 No |] ER/Outpati | ent 3 DOA Oth | er: 4 Nursing H | ome 5 Residenc | e 6 K lOther (Sp | pecify) HOSPICE |
| n: T | 27. Manner of Death 28a. Date of Injury (Month, Day Year) | 28b. Time Injury | | y at k? | 28d. Describe how i | njury occurred | |
| atio | 1 X Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation | ,, | | Yes 2 □ No | | | |
| lifica | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At h | ome, farm, s | street, factory, office | | 28f. Location (Stree City or Town, S | | Rural Route Number, |
| Cert | | | | | | | |
| cal | 29a. Certifier (Check only) 1 Certifying Physician: To the best of my kn | owledge, de ation and/or | ath occurred at the ti investigation, in my | me, date and place opinion, death occu | , and due to the caus rred at the time, date | e(s) and manner and place, and d | as stated. ue to the cause(s) |
| Medical Certification: To | one) and manner stated. | | 29c. Licens | | | Date signed (Mo | |
| 2 | 29b. Signature and fitle of certifier | | Too. Licens | | | , | |
| | 7 0 1 1 2 | | |)4372 | J | 11/19/0 | 16 |
| | 30. Name and address of person who completed cause of death (ite | | | MT1(01177* - | MD 01000 | | |
| | DR. TARIQ MAHMOOD 2300 DULANI 31. Date filed (Month, Day, Year) 32. Begistrar's Sign | | LEY KD. | LIMUNIUM, | MD 21093 | | |
| ite rar | BLOW O O TOTAL | 20 | And - | | | | |
| | 110 4 K O (UUB Maleres | 15 16 | STATE OF | | | | |

ORIGINAL

| | Darking | | For Stata Registrar | State of | Maryland , | | artment <i>tificate</i> | | | and M | | jiene 10g. No. | 06 | 375 | 81 |
|----------------------------|--|-----------------|---|---|--|------------------------------------|--|-----------------------------|--------------------|--------------------------|--|--|--|--|--------------------|
| .38 3 % 6 | Physici /Medic | | 1. Decedent's Name (First, Middle, Last) Thomas | RDAKOU | ski | | | | | | 2. Date of Dea Month | Day S | 2006 | 3. Time of 0 | |
| 4 4 | Examir | | 4a. Facility Name (If not institution, give state) 4114 Harris Avenue 5. Social Security Number 6. Sec | <u> </u> | er) Age (In yrs. last | hirthday | 4b. City, 1 | Ba1t | imor | e | 8. Date of Birth | | Balti | more | Faraian |
| . 24 | Funeral Director | | | M 2□ F | 60 | Yrs. | Months | Days | Hours | Min. | (Month, Day Sept 13 | Year) 3, 194 | 6 Ma: | nplace (State or intry) ryland | |
| | e Marylan 3a-f show tifled at | ctor | 10a. State 10b. County MD Baltimo | re | 10c. City, T | | cation 1timo | re | | | | | | 10d. Inside City | |
| | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itama 23a or 28a-f show faumatic event, the Michola Examiner runt be partitled at | Funeral Directo | 10e. Street and Number 4114 Harris Avenue 11. Marital Status 1 □ Never Married 2 ☒ Married | 12. Was Decede Armed Force | es? | 13. | Vas Decedi Yes, spec | 2 | 1234 spanic Ori | gin? (Spe i, Puerto i | cify Yes or No- Rican, etc.) | | of What Cou USA Race - Amer Black, White | ican Indian, | |
| Maryland 21215-0036 | thin 72 hours af e. en "natural", or M.olcal Exert | Completed by I | 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) | | 1 | 6a. Deced | 1 ☐ Yes 2 dent's Usua kind of won DO NOT us | l Occupa | uring most | t of workii | unk | | f Business/l | hite | unk |
| yland 21 | B a b ≥ | To Be Con | 11 17. Father's Name (First, Middle, Last) Walter Albert Ord | | | | | | H | le1en | (First, Middle, | kowsk | i | | |
| Baltimore, Mar | permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 Is marke any Injury or other traumatic <u>once.</u> | | 19a. Informant's Name/Relationship (Ty Helen Ordakowski/ 20a. Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Sonature of Funeral Service License | spouse emoval from Sta | 20b. Place ceme | 15 F e of Dispo etery, crem | ore Co sition (Nam natory or ot | Ourt ne of ther place | Balt | imor | ore, MD Pate | 21221 20c. Locatio | on - City or 1 | own, State | |
| 8760, | Physician /Medical Examiner | dicai Examiner | 23a. Pant. Enter the disease, or complished, or heart failure. List only or immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or | as a consequen as a consequen as a consequen | ce of): | ocor | of dying | , such as | | | | | Approximate Interval Betwoonset and De 10 Mg | |
| .O. Box 6 | ne death certifi the attending I thed for use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 1 ☐ Live birti | me of pregnancy n 2 ☐ Fetal de t at time of death n | ath 3[| Ectopic pre Other (spe | | | | | | Date of delive | very Day Ye | ear |
| <u> </u> | ires that signed b d be deta | by | Part II. Other significant conditions cor | ntributing to deal | h but not resultin | ng in the u | nderlying ca | use give | n in Part I. | | | bacco use c | | the cause of de | / |
| al Reco | | Completed | OS Wasserstand | | | | | | | | | sy med? 2 ☑ No | b. Were aut prior to c death? 1 \(\text{Yes} | opsy findings avoint of cau | vailable use of |
| Division of Vital Records, | ding Phys | atlon: To Be | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | ospital: 1 Inp 28a. Date of (Month, | | /Outpatien b. Time of Injury | t 3 DO | Bc. Injury Work | r: 4□Nu | rsing Hor | (Check only or me 5 Thesid 28d. Describe h | ence 6 🗆 (| | - ufy) | |
| Divis | oltal or Attenors after death | Certification: | 3 Suicide 6 Could not be determined | building | Injury - At home , etc. <i>(Specify)</i> | | | | | | 28f. Location (S City or Tow | n, State) | | | 9r, |
| | To the Hospital or Al within 24 hours after of To the Funeral Direc completely fitted in by | Medical | 29a. Certifier (Check only one) 2 Medical Exeminate of certifier | sicien: To the be ner: On the bas and manne | s of examination | dge, death and/or in | vestigation, | in my op | inion, dea | d place, a th occurre | ed at the time, d | ause(s) and late and place 29d. Date sig | e, and due | to the cause(s) | |
|) | E 2 E 8 | | 30. Name and address of Parson who co | moleted cause | of death (Item 22 | la) (Type | | D | 446 | 40, | | n / | -1. | 6 | |
| | Sta | | 31. Date filed (Month, Day, Year) | IEG | istrar's Signature | 09+ | tres | 08C | Re | 5 | Suite 1 | = ' | PERK | ille MD | 2123 |
| 9 | Registi | ar | NOV 2 8 2000 | Call Sol | and Som | Sept Miles | and the same | | | | | | | | |

Please Type or Print in Black Indelible Ink

| Physicia Medical Examin | n/ | 1- For State Registrar 1. Decedent's Name (First, Middle,Last) Mary P. Osborne | 2. Date of Dea | eg. No. 2006 3758 th 3. Time of Death r 21, 2006 2006 hrs |
|---|-----------------|---|---|--|
| | | | ity, Town, or Location of Death Osedale | 4c. County of Death Baltimore County |
| Funeral Director | | 215-68-1436 _{1 M 2} X _F 51 Yrs. | lonths Days Hours Min | th(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD |
| land f show any once. | tor | Usual Residence of Decedent 10a. State 10b. County Baltimore Rosedal | | 10d. Inside City Limits 1 Yes 2 X No |
| the Mary | Director | | 21237 | 0g. Citizen of What Country? USA |
| 2 hours afte "natural", | eted by Funeral | Armed Forces? If Yes, s Never Married X Married Armed Forces? If Yes, s No Yes X No If Yes | cedent of Hispanic Origin? (Specify Yes or No pecify Cuban, Mexican, Puerto Rican, etc.) 2 No specify: sual Occupation (Give kind of work done f working life. DO NOT use retired) | White, etc. Specify: White 16b. Kind of Business/Industry |
| -0036 I within 7 giene ther than | Completed | 4yrs Mass 17. Father's Name (First, Middle, Last) | age Therapist [18.Mother's Name (First, Middle, I | Medical Maiden Surname) |
| 1215. de files files fantal Hy narked of event, th | Be | Robert Osborne | Margaret Andress (Street and Number or Rural Route Num | rthur |
| MD 2 Id 2 shoul Ilth and N 27 is m 27 is m | ř | John Coiley / husband 10 Ba | rdia Court Baltimo | ore MD 21237 |
| Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medica | | 4 Denation 5 Other Specify: | l Cemetery 11/27/0 | 20c. Location - City or Town, State 6 Baltimore MD |
| | | Kalut tun Connelly h co | nnelly Funeral Hor | e Ave.Balto. MD me of Essex 21221 |
| Physician /Medical Examiner | | 2 a. Part I. Enter the disease or complications that caused the death. Do not enter the metalline. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): | | est, shock, or heart Approximate Interval Between Onset and Death |
| / | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of): | | |
| executed an and | cal E | | | |
| Ox 687 ath certifi | Physician/Med | #23a,27,penYIE, g802, IF FEMALE: 23c. If yes, outcome of pregnancy | | 23d. Date of delivery Month Day Year |
| S, P.O. Baquires that the de | 2 | Part II. Other significant conditions contributing to death but not resulting in the under | | obacco use contribute to the cause of death? s 2 ✓ No 3 Probably 4 Unknown an 24b. Were autopsy findings available |
| Record: The law rec | Completed | | autop perfo 1 ✔ Yes | prior to completion of cause of rmed? death? |
| Division of Vital Records, To the Hospital or Attending Physician: The law requirements after death. To the Funeral Director: After this certificate has been sompletely filled in by the funeral director, page 2 should | tion: To Be | 25. Was case referred to medical examiner? 1 V Yes 2 No 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury | | Residence 6 Other: |
| Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, farmation (Specify) | ctory, office building, etc. 28f. Location (or Town, S | Street and Number or Rural Route Number, City state) |
| To the Hos within 24 h | Medical (| 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated. | • | |
| E 3 E 3 | Me | 29b. Signature and title of certifier | 29c. License number O.C.M.E. | 29d. Date signed (Month, Day, Year) November 22, 2006 |
| | İ | 30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn S | treet, Baltimore, MD 21201 | |
| Sta Registr | | | <u>ر</u> | |
| DHMH 17 Rev 1/20 | 001 | ORIGINAL | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37583 Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Year Month 1545 VIEr 2006 en 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) WALKERSVILLE FREDERICK NURSING CENTER GLADE VALLEY Birthplace (Stete or Foreign Country) If Under 1 Year 6. Sex 7. Age (In yrs. lest birthday) Date of Birth (Month, Dey, Year) 5. Social Security Number Days Hours 1 □ M 2 🛛 F Months 96 OHIO 354-50-6559 3/6/1910 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No WESTMINSTER CARROLL 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 407 BARNES AVE. USA 21157 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No if Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: WHITE 3℃ Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondary (0-12) 12 2 NURSE HEALTH 18 Mother's Name (First Middle Maiden Surname) 17. Father's Neme (First, Middle, Lest) UNKNOWN **JASTRAUB** JOSEPH MARY 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 407 BARNES AVE., WESTMINSTER, MD 21157 RUTH A. ENSOR - DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition ⊁X Burial 2 ☐ Cremation 3 ☐ Removal from State ST. JOSEPH CATHOLIC CEM.11/25/06 EMMITSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) ignature of Puncial Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 eese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) dweeks Nexulualia Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or as a consequence of): Due to (or as e consequence of): resulting in deeth) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? abetes Wellitus 24a. Wes an autopsy performed? 1 Yes 2 KNo 1 ☐ Yes 2 ☐ No

Physician /Medical Examine

Physician

/Medical

Examiner

10a, Stete

MΠ

Director

Funeral

þ

Completed

ဥ

Funeral

Director

or items 23s or 28s-f show

th and Mental Hygiene. 7 is marked other than "natural", or frems 23s or 28s-f shor traumatic event, the Medical Examines must be notified at

with the Maryland

Physician/Medical Examiner Medicai Certification: To

use as the bunal-transit paga 2 should be

or Attending Physician: The law requiras that the death certificate be executed cartificate After this after death. fillad in by

Division of Vital Records, P.O. Box 68760,

Be Completed by 25. Was case referred to medical

To the Hospital o within 24 hours af To the Funeral DI completely filled in

State Registrar

nd title of contifier

5 Pending investigation

6 Could not be determined

11810 Dete filed (Month, Day, Year,

1 Yes 2 No

27. Menner of Death

2 Accident

4 - Homicide

3 Suicide

29a. Certifier (Check only one)

29b. Signature

32. pegistrer's Signeture

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Dete of Injury (Month, Dey Year)

and manner stated.

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

who completed cause of deeth (Item 23e) (Type, Print)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

2006

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2006 Year Ho1combe Polen November

Months

7. Age (In yrs. last birthday)

10c. City, Town or Location

Laurel

79

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

Min.

Silver Spring

Days

8:51

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

10 Months

1x□Yes 2□No

9. Birthplace (State or Foreign

Washington, D.C.

4c. County of Death

Montgomery

Black, White, etc

8. Date of Birth (Month, Day, Year) 01/03/1927

Physician /Medical Examiner

4a. Facility Name (If not institution, give street and number)

10b. County

Prince Georges

1 □ M 2 X F

Holy Cross Hospital

5. Social Security Number

Usual Residence of Decedent

214-28-4710

10a. State

Maryland

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at the Medical 7 Is marked other traumatic event, the Department of Health ar Important: If Item 27 Is any injury or other trau once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

Examiner physician and s the burial-tran Physician/Medical ģ signed t Completed by page 2 certificate Be ဥ this After Certification: hours after death. Director: within 24 hours are.

To the Funeral Direct

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8703 Graystone Lane 20708 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 N If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Specify: White 1 ☐ Yes 2 ☒ No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Crossing Guard Public School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk Geraldine Fairall ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Polen / Son 975 Saint George Barbara Road Davidsonville, MD 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery 5 ☐ Other (Specify) 11/30/2006 4 ☐ Donation Leesburg, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Well. Fleck Funeral Home 7601 Sandy Spring Road Laurel, MD 20707 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary Embolus Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2x No 3 Probably 4 Unknown 24a. Was an autopsy performed: 2<mark>√</mark> No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🛮 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/24/06 au Clike D0061937 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

CANDACE L. WILSON, MD - 1500 FOREST GLENRD, SILVER SPRING MD 20910

| | | | For State Registrar | State of Maryland | | artment of H | | and Me | | | 06 | 37585 |
|-------------------|--|------------------|--|---|--------------------------------|--|-----------------------------|---------------------------|-------------------------|-----------------------------------|---------------------------|--------------------------------------|
| × 4 | 4 | | Decedent's Name (First, Middle, Last |) | | | | | 2. Date of Dea Month | | Year | 3. Time of Death |
| | Physicia /Medic | | CLINTON PAINE | PITTS | | | | 1 | OVEMB | ER 22 | 2006 | 5:30p ^M |
| | Examin | | 4a. Facility Name (If not institution, give | street and number) | | 4b. City, Town, o | | f Death | | 4c. County | | _ |
| 4 | | ign . | BLAKEHURST 5. Social Security Number 6. Se | x 7. Age (In yrs. la | est hirthday) | TOWS(| ON If Under 2 | 24 Hrs. | 8. Date of Birth | | P. Birthol | RE ace (State or Foreign |
| | Funeral Director | | | M 2□F 92 | Yrs. | Months Days | Hours | Min. | 09/6/1 | 914 | Count | LAND |
| * | D | | Usuel Residence of Decedent | | | | | | | | | |
| | arylen ahow | <u>.</u> | 10a. State 10b. County | | , Town or Lo | | | | | | 10 | 0d. Inside City Limits 1 ☐ Yes 2 7No |
| | 28a-f | ecto | MD BALTIMO | DRE | TOWS | JN 10f. Zip Code | | | | Og. Citizen of | What Coun | |
| | death with the Maryland me 23a or 28a-f show rmust be rediffed at | Funeral Director | 1055 WEST JOPPA | מא א | | | 1204 | | | USA | TTHAT GOLD | ,. |
| | ne 23 | era | 11. Marital Status | 12. Was Decedent Ever in U.S | S. 13. | Was Decedent of H | | gin? (Spec | rfy Yes or No- | | ce - America | |
| ٥ | after or Ite | | 1 Never Married 2 Married | Armed Forces? 1 (3)Yes 2 □ No 1f Yes, Give | | 1 ☐ Yes 2 █No | an, mexican Specify: | i, Puerto H | ncan, etc.) | Specif | ick, White, e | etc. |
| 215-0036 | filed within 72 hours after Hygiene. ther than "naturel", or Ite ant, the Medical Examina | d by | 3 XWidowed 4 ☐ Divorced | Year or Dates: | | | | | | | MHI | |
| Ϋ́ | n 72 h "nati | Completed | 15. Decedent's Edi (Specify only highest grad | | (Give | dent's Usual Occup kind of work done DO NOT use retired | during most | t of workin | g | 16b. Kind of B | usiness/ind | lustry |
| 7. | withi | dwo | Elementary/Secondary (0-12) | College (1-4or 5+) | ATTO | ORNEY | , | | | LAW | | |
| פ | ~ - 0 = | 0 | 17. Father's Name (First, Middle, Last) | | | | 18. Mothe | r's Name | (First, Middle, | Maiden Sumar | ne) | |
| Maryland | should be ind Mental marked o | To B | TILGHMAN G. 1 | PITTS | , | | DORO | THY | M. PA | INE | | |
| Jan | 2 6 8 | | 19a. Informant's Name/Relationship (T | | | ng Address (Street | | | | | | |
| | s 1 and if Health Item 27 other tr | | HENRY C. PITTS 20a, Method of Disposition | | | 57 IRISE | H AVE | | ONKTON ate | , MD . 2 20c. Location | | |
| בַ | Pages nent of It int: if Ite | | 1 Burial 2 Cremation 3 | Removal from State | EN MO | matory`or other plac | | | | BALTO | • | |
| altımore, | iit. Pa artmer artant ortant Injury | | 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Fugegal Service Licen | | | OIN I 2. Name and Addre | | | 2000 | DALIC | J.CII | I,MD. |
| n | permit. Pages Department of Important: ff I any Injury or one | | MA la | rugh | | | | | $8 \sqrt{8} \sqrt{8}$ | ONS CO |) 2111 | 1 . |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | lications that caused the death | . Do not ent | | | | | | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | Preum | ONIA | | | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a consequ | ence of): | | | | | | | |
| 7.0 | Examine | er | Sequentially list conditions, | b. Due to for as a consequ | ones offe | | | | | | | |
| | ted nsit | | cause. Enter Underlying Cause (Disease or injury | Later to the state of the table | O'HAD LITY | | | | | | | |
| ~ | be executed sicien and burial-transit | Examin | that initiated events resulting in death) Last | c. Due to (or as a consequ | ence of): | | | | | | | |
| 760, | te be ysicie | cal | | d. | | | | | | | | |
| 89 | ntifica ng ph s as th | Med | IF FEMALE: | | | | | | | | - | |
| Box | death certifice e attending ph d for use as t | Physician/Med | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal | death 3 | Ectopic pregnancy | <i>y</i> | | | | ate of delive onth | ry Day Year |
| | | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Pregnant at time of de 9□ Unknown | eatn 5L | Other (specify) _ | | | | | | |
| J. | law requires that the as been signed by th 2 should be detache | | Part II. Other significant conditions co | ontributing to death but not resu | Ilting in the u | inderlying cause giv | en in Part I. | | 23e. Did to | bacco use con | tribute to th | e cause of death? |
| Records, | w requires been sign should be | ed by | | | | | | | 1 🗆 Y | es 2□No | 3 🗌 Prob | ably 4 Unknown |
| O O | aw recis bee | piet | S. | | | | | | 24a. Was a | an 24b. | Were auto | psy findings available |
| ž | The ete h page | Completed | | | | | | | perfor | med? 2 No | death? | 2 No |
| ita | ician: Th certificete rector, pag | Bec | 25. Was case referred to medical examiner? | | | | | of Death | (Check only or | 18) | | |
| <u> </u> | hys his | ၉ | 1 ☐ Yes 2 ☐ No | | ER/Outpatie | | 4 Lanu | | | ence 6 Oti | | /) |
| Division of Vital | ing Afte une | ion | 27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time o Injury | Wo | ryat rk? ∣Yes 2 🔲 i | | 86. Describe n | ow injury occu- | ilea | |
| isi. | Il or Attending Patter death. I Director: After to in by the funera | fica | 3 Suicide 6 Could not be | 28e. Place of Injury - At ho | me, farm, st | | | | | | ber or Rura | l Route Number, |
| 2 | s after | Certification: | 4 Homicide determined | building, etc. (Specify | <i>'</i>) | | | | City or Tow | m, State) | | |
| | To the Hospital within 24 hours a To the Funeral Completely filled | Medicai (| 29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam | ysician: To the best of my knowiner: On the basis of examinate and manner stated. | wledge, deat tion and/or in | th occurred at the traverse to the traverse to the traverse traverse to the traverse traverse to the traverse traverse traverse to the traverse tra | me, date an opinion, dea | nd place, a th occurre | nd due to the o | cause(s) and m date and place, | anner as st and due to | ated. the cause(s) |
| | To the within 2 To the complet | Mec | 29b. Signature and title of certifier | and manner stated. | | 29c. Licens | se number | | | 29d. Date sign | ed (Month, | Day, Year) |
| ı | ⊢ S ⊢ ŏ | | > Willing | · molom | ~ | 0 | 1218 | 29 | | Nov. | 242 | -006 |
| | 171 | | 30. Name and address of person who | completed cause of death (Item | 23a) (Type | | | | | 1 | | |
| | 1000 | | | ONNELL M.D. | 6301 | N. CHAI | RLES | ST. | BALTO | .,MD. | 2121 | 2. |
| A. | Sta Regist | | 31. Date filed (Month, Day, Year) | 32. Registrar's Signa | ture | Carles | | | | | | |

DHMH 17 Rev 1/2001

| | | | For State Registrar | State of M | larylan | | artmen rtificat | | | and M | | giene Reg. No | Z 11 11 10 | 37586 | - |
|-------------|--|------------------|---|---|--|------------------------|---------------------------|--------------------|-------------|------------|---|------------------------|----------------------|--|---|
| | Physici | | 1. Decedent's Name (First, Middle, | Last) | | | | | | | 2. Date of De Month | ath Da | y Year | 3. Time of Death | |
| | /Medic | | Helen | Mabe1 | | Parr | | | | | Knewps | 6 7 | 1 200 | 6 12:35 PM | |
| | Examin | er | 4a. Fecility Name (If not institution, | |) | | 0. | - | Location o | f Death | | 0 | . County of Dea | ath | |
| | | | 5. Social Security Number | | Cente | last birthday) | If Under | | If Under | 24 Hrs | 9 Date of Bir | | une Mu | undel | _ |
| Н | Funeral Director | | 231-20-6029 | 1□M 21 F | 90 (iii yis. 7: | | Months | Days | Hours | Min. | 8. Date of Bir (Month, Da Sep. 30 | iy, Year, | 8 | rthplace (State or Foreign country) VA | 7 |
| | | | Usual Residence of Decedent | | | | | | | | БСРТЭО | , 1, 2 | | V21 | _ |
| | how | _ | 10a. State 10b. County | | | ty, Town or Lo | | | | | | | | 10d. Inside City Limits | |
| | Ba-f e | cto | | runde1 | G1e | n Burn | ie | | | | | | | 1 ☐ Yes 2√∑No | |
| | vith th | Funeral Director | 10e. Street and Number | | | | 10f. Zip | | | | | - | tizen of What C | Country? | |
| | e 23g | erai | 213 Sunset Driv | 12. Was Deceden | Everio II | 6 12 1 | 210 | | | -:-0 (0 | -4 V N- | | S.A. | adaa ladia | _ |
| | ter de | Š | 11. Marital Status 1 ☐ Never Married 2 ☐ Marrie | Armed Forces | 7 | | | | n, Mexican | , Puerto i | cify Yes or No Rican, etc.) |)- | Black, Wh | ite, etc. | |
| 20 | urs al | by | 3 Widowed 4 Divorced | If Yes, Give Year or Dates: | | | 1 🗆 Yes | 2 X No | Specify: | | | | Specify: W | hite | |
| 21215-0036 | be filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene do ther than "natural", or Iteme 23s or 28s-f ehow event, the Madical Examiner must be notified at | Completed | 15. Decedent' (Specify only highest | | | 16a. Dece | dent's Usua kind of wo | al Occupa | ition | of works | 200 | 16b. K | and of Business | s/Industry | _ |
| 7 | ithin ie. | npie | Elementary/Secondary (0-12) | College (1-4or | 5+) | life. | DO NOT us | se retired) |) | OF WORK | ng . | | | | |
| 7 | e filed with Il Hygiene other tha | Co | 8 | | | Hor | nemak | er | 40.14.0 | | | | ome Own | er | |
| anc | ould be fi Mental F arked ot atic ever | Be | 17. Father's Name (First, Middle, L | ast) | T7 - J - | | | | | | (First, Middle, | | i Sumame) | | |
| Maryland | 2 should be and Mental le marked craumatic ev | ဥ | 19a. Informant's Name/Relationsh | in (Type Print) | Wade | 19h Mailir | ng Address | (Street a | | | Nunnall | | or Town, State, | Zin Coda) | _ |
| <u>8</u> | mit. Pages 1 and 2 should b partment of Health and Menis portant: If Item 271e marked y Injury or other traumatic e £8. | | Mrs. Judy Jester | | | | | | | | Burnie, | - | | 21p C000) | |
| <u>ნ</u> | s 1 and t Health Item 27 other tr | | 20a. Method of Disposition | | 20b. F | Place of Dispo | | | | Nov. | - | | ocation - City o | r Town, State | _ |
| Ë | Pages nent of int: If It iry or o | | 1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (Sp | | , l | esapeal | | | | 200 | | Ste | vensvil | le. MD | |
| Baltimore, | permit. I Departm Importal eny Injui | | 21. Signature Funer Service L | icersee 100 | | | | | | y Sin | gleton | | | me, P.A. | |
| מ | Depril | | Lanusur | suc M | 0136 | 1 1 | | | | | | | e, MD 2 | | |
| | | | 23a. Part 1. Enter the disease, or a shock, or heart failure. List of | complications that cause nly one cause on each | d the deat | h. Do not ent | er the mod | e of dying | , such as | cardiac o | r respiratory a | rrest, | | Approximate Interval Between | |
| <u>,</u> | Physician | | Immediate Cause (Final disease or condition | sep | tic | Show | ck | | | | | | | Onset and Death | |
| | /Medical Examiner | | resulting in death) | Due to (on a | s a conseq | uence of): | | | | | | | | 00 | _ |
| | LXummer | _ | Sequentially list conditions, if any, leading to immediate | b. Due to (or as | UM | ory C | <u></u> | | | | | | | Day | |
| | nsit | Examiner | Cause. Enter Underlying Cause (Disease or injury | Due to (or as | s a conseq | derice oi). | | | | | | | | U | |
| | be executed sicien and burial-transit | Exar | that initiated events resulting in death) Last | CDue to (or as | s a conseq | uence of): | | | | | | | | | |
| | ite be ex ysicien ye buria | call | | d | | | | | | | | | | | |
| Š | | | | | | | | | | | | | | | _ |
| X Q | eath certitic attending p | an/h | IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/hths? | 23c. If yes, outcome 1 ☐ Live birth | | | Ectopic pr | egnancy | | | | | 23d. Date of de | . , | |
| | the at | Physician/Med | 1 Yes 2 No | 4□Pregnant a 9□ Unknown | at time of d | eath 5 | Other (sp | ecify) | | | | | Month | Day Year | |
| Į. | w requires that the de been signed by the should be detached | | Part II. Other significant condition | s contributing to death | hut not res | ulting in the u | nderlying c | ause ave | n in Part I | | 23e Did to | obacco | use contribute t | to the cause of death? | _ |
| ďs, | sign d be | Completed by | Respicatory | TOULLE | | Reno | 2/ 6 | Mil | Ne | | | res 2 | | robably 4 Dunknown | |
| cord | w req | lete | | (5-1-2-5- | 1 | | | | | | 24a. Was | 20 | 24h Word a | utopsy findings available | _ |
| Ë | sician: The law certiticete hes t rector, page 2 s | E C | | | | | | | | | autop | rmed? | prior to death? | completion of cause of | |
| | | 0 | 25. Was case referred to medical | | | | | | 26 Place | of Death | 1 ☐ Yes | 2 is No | 1 L Ye | s 2 No | |
| <u>></u> | Physici this cer | ToB | examiner? 1 □ Yes 2 No | Hospital: 1 Minpati | ient 2 🗆 | ER/Outpatien | t 3 DC | A Othe | r- | | | | 6 □Other (Spe | ecify) | |
| Ö | ding Phys h. After this funeral dir | | 27. Manner of Death 1 ☑Natural 5 ☐ Pending | 28a. Date of Inj (Month, D. | ury ay Year) | 28b. Time of Injury | 2 | 8c. Injury Work | | | 8d. Describe h | | | | П |
| <u> </u> | tendil eath. for: A the fu | cati | 2 Accident investigation in Suicide 6 Could no | ation | | | М | 1 🗆 Y | es 2 □ N | | | | | | |
| DIVISION | To the Hospitel or Attending Physician: within 24 hours elter death To the Funeral Director: Atten this certition completely filled in by the funeral director. | Certification: | 4 Homicide determin | led 286. Place of in | ijury - At ho itc. <i>(Specif</i>) | ome, farm, str v) | eet, factory | , office | | 2 | 8f. Location (8 City or Tox | Strøet ar vn. State | nd Number or A 9) | lural Route Number, | |
| | spitel ours ours neral filled | | 29a. Certifier 15 Certifying | Physician: To the best | of my kno | wledge death | occurred | at the time | e date and | 1 niace a | and due to the | caucole | and manner a | e stated | |
| | • Ho 24 h • Fur letely | edical | (Check only 2 Medical E | xaminer: On the basis of and manner s | ot examina | tion and/or inv | estigation, | in my op | inion, deat | h occurre | d at the time, | date and | d place, and du | e to the cause(s) | |
| | To th Within To th comp | Me | 29b. Signature and title of certifier | 7 | 1 . | | 290 | License | number | | , | 29d. Da | te signed (Mon | th, Day, Year) | - |
| | | | Maua | GUILLE | MC |) | 1 | 000 | 732 | 74 | 4 | Nove | mba. | 212006 | |
| | 11 | | 30. Name and address of person | mpleted cause of | death (Item | 23a) (Type, | Print) | 1 | 11 | | | | 11.00 | | |
| / | 7 | | MARYA CAVIR | AMD | 301 | 4 to> | ntal | d | 631 | en. | Buryi | | [W 2 | 1061 | _ |
| | Sta Registr | te ar | 31. Date filed (Month, Day, Year) NOV 2 8 | 2006 | rar's Signa | III III | | | | | | | | | |

| | | | State of Maryland / Department State of Maryland / Department / | artment of Health and 16. Jh Tificate of Death | Mental Hygiei | ne N2006 37 | 1587 |
|---------------------|--|----------------|---|--|--|---|----------------|
| | | | Decedent's Name (First, Middle, Last) | | 2. Date of Death | 3. Tim | ne of Death |
| | Physici /Medio | | Beverly Sasser Preston | | NOVEMBE 2 | 2006 O1. | 40 AM |
| | Examir | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Dea | | 4c. County of Death | |
| | | | BACTIMORE WASHINGTON MEDICAL CEN | TEZ GLEN BU | | GAINE ARU | NIDEL |
| ľ | Funeral Director | | 5. Social Security Number 6. Sex № 7. Age (In yrs. last birthday) 531–20–2842 1□ M 2☒F 81 Yrs. | If Under 1 Year If Under 24 Hi Months Days Hours Min | | 9. Birthplace (Sta 2925 WA | ate or Foreign |
| | and | | Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Lo | ocation | | 10d. Insid | le City Limits |
| | Maryl f ehc | ō | MD Anne Arundel Glen Burni | 0 | | 1 🗇 | Yes 2∑No |
| | 1 the | Director | 10e. Street and Number | 10f. Zip Code | 10g. | Citizen of What Country? | |
| | 3a or | 0 | 172 Margate Drive | 21060 | USA | | |
| | ma 2 | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. 13. | Was Decedent of Hispanic Origin? | Specify Yes or No- | 14. Race - American India | n, |
| Maryland 21215-0036 | be filed within 72 hours after death with the Maryland hat hygiene. Id other then "naturel", or itema 23a or 28a-1 show event, the Madical Examinar must be mailled at | by | 1 Never Married 2 Married 1 1 Yes 2 No | If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 No Specify: | ino Rican, etc.) | Black, White, etc. Specify: White | |
| 5-0 | 72 hc | etec | | dent's Usual Occupation kind of work done during most of w | orkina 16b | . Kind of Business/Industry | |
| 2 | vithin ne. hen | Completed | Elementary/Secondary (0-12) College (1-4or 5+) | DO NOT use retired) | | | |
| 12 | filed v Hygie other t | | 17 Father's Name (First Middle / ast) 2 1 1 2 2 | | ame (First, Middle, Maid | narmaceutical | |
| au, | 2 should be filled withir and Mental Hygiene. ie marked other then aumatic event, the Ma | Be C | 17. Father's Name (First, Middle, Last) Roland J. Dresen WILLIAM Sasser | _ | te Isaacsor | | |
| 2 | should ind Men marke | 2 | WIEDIE DUDGE | ng Address (Street and Number or I | | | |
| | and 2 sealth ar | | | argate Dr.; Glen | | | |
| <u>6</u> | 는 글 돌 돌 | | 20a Method of Disposition 20b. Place of Dispo | sition (Name of | | Location - City or Town, Stat | 0 |
| E | 00- | 1 | | | 006, Ste | evensville, MD | |
| Baltimore, | 교통원률 | | Cen | ter 2. Name and Address of Facility | 000 | ond Ave. SW | |
| ä | Dep in ben a part | | M01411Si | ngleton Funeral | Home; Glen | Burnie, MD 21 | 061 |
| П | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. | er the mode of dying, such as cardi | ac or respiratory arrest, | Approxi | Between |
| 1 | Physician | | Immediate Cause (Final disease or condition ACUTE MYOUA | POIAL INFA | ECTION | Onset a | and Death |
| | /Medical | | resulting in death) Due to (or as a consequence of): | , | | | |
| | Examiner | | Sequentially list conditions, if any, leading to immediate b. UNG CANCE Due to (or as a consequence of): | 7 | | | |
| | at sit | iner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | | | | |
| | cate be executed physician and the burial-transit | Examin | that initiated events c. resulting in death) Last Due to (or as a consequence of): | | | | |
| 8760, | be e Sician buria | alE | | | | | |
| 687 | | edical | d | | | | |
| P.O. Box | The law requires that the death certific to has been signed by the attending rage 2 should be detached for use as | Physician/Me | | Ectopic pregnancy Other (specify) | | 23d. Date of delivery Month Day | Year |
| | es that igned by be deta | | Part II. Other significant conditions contributing to death but not resulting in the u | nderlying cause given in Part I. | 23e. Did tobacc | co use contribute to the cause | of death? |
| Vital Records, | quires n sigr | d by | | | 1 🗆 Yes | 2 No 3 Probably 4 | Unknown |
| 00 | s been si | Completed | | | 24a. Was an | 24b. Were autopsy finding | ngs available |
| Re | The lay | E O | | | autopsy performed | | of cause of |
| ital | | 0 | 25. Was case referred to medical | 26. Place of D | 1 ☐ Yes 2 ☑ eath (Check only one) | 10 103 20 10 | |
| Į V | d: 5 | To B | examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatier | t 3 DOA Other: 4 Nursing | Home 5 ☐ Residence | 6 Other (Specify) | |
| ion of | | | 27. Manner of Death 1 | 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No | 28d. Describe how in | njury occurred | |
| Division | ospital or Attendours after death hours after death uneral Director: ly filled in by the | Certification; | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify) | eet, factory, office | 28f. Location (Street City or Town, St | and Number or Rural Route (ate) | Vumber, |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | edicai (| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatt 2 Medical Examiner. On the basis of examination and/or in and manner stated. | n occurred at the time, date and place vestigation, in my opinion, death occurred to the control of the control | ce, and due to the cause curred at the time, date a | e(s) and manner as stated. and place, and due to the cau | se(s) |
| | To t To t | W | 29b. Signature and title of certifier N. (| 29c. License number D 45149 | | Date signed (Month, Day, Yea | |
| / | 18 | | 30. Name and addless of person who completed cause of death (Item 23a) (Type, | Print) Elen 3 | whie n | 10 2061 | |
| 65 | Sta Registi | | 31. Date filed (Month, gay, Year) 32. Registrar's Signature | actes | | | |
| | | | MARY O CARD WARRY TO SEE | maGeograph | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 4:20 a. M November 27, 2006 Saroj Parasuraman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 6624 Marywood Road Bethesda If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🛣 F 1936 India 70 May 15, 523-80-4095 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States of America 6624 Marywood Road 20817 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Specify: Asian Indian þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) University College Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be T.S. Parasuraman Rukmani Iyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type Print) 6624 Marywood Rd., Bethesda, Maryland 20817 Raja Parasuraman / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. 29. 1 Burial 2 Cremation 3 Removal from State Montgomery Crematorium, Inc.2006 Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/BethesdaChevy Chase, Inc. 7557 Wisconsin Ave.
Bethesda, Maryland 20817 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Live 23a. Part1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arrhythmia Due to (or as a consequence of): End Stage Parkinsons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Dnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Dysphagia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 2 🔯 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42518 November 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gul Chablani, M.D., 11119 Rockville Pike #401, Rockville, Maryland 20852

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

NOV 2 8 2006

Funeral

Director

•how

r than "natural", or iteme 23a or 28a-f ehov The Madical Examiner must by notified at

other than

permit. Pages 1 and 2 should be Department of Health and Mental Important: If I tem 27 is marked on yinjury or other treumatic events.

Physician

/Medical

Examiner

ng physicien and as the burial-transit

attending

esn

jo

ned by the a

cate has been signed page 2 should be det

ours after death.

neral Director: After this certific filled in by the funeral director,

5

To the Hospitel within 24 hours a To the Funeral

death certificate be executed

Box 68760

P.O.

Records,

Division of Vital

within 72 hours after

2 should be f and Mental h

Maryland 21215-0036

Baltimore.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 24, 2006 **Physician POLLACK** 9:59 A IRMA В. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 130 SLADE AVENUE #424 BALTIMORE If Under 24 Hrs. Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 👿 F Months Davs 212-20-8655 Director 82 08/27/1924 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at MD BALTIMORE 1 □Yes 21 No Funeral Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be 1. 130 SLADE AVENUE #424 21208 U.S.A 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify Be Completed by 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LEGAL TECHNICIAN U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MAURICE Ε BASKIN 2 ANNA FRIEDMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON SZARONOS / DAUGHTER 618 MASEFIELD CIRCLE - VIRGINIA BEACH VA 23452

Date of Disposition (Name of 20c. Location - City of Town, State 20b. Place of Disposition (Name of LIBERTY PARK 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11/26/2006 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) CONG an A Mass of Facility SOL LEVINSON & BROS., INC. 21. Signature, of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed the burial-tran and Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) 1 🗆 Yes the 2√No 9☐Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2D No 24a. Was an certificate has autopsy performed? Yes 211 No 1☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes Z No Other: 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury (Month, Day Year, 1 Natural 5 Pending 1 ∏Yes 2 ☐ No death. Director: / investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar ere and title of certific

Day.

31. Date filed (Month.

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1838

29c. License number

| | | | For State Registrar | State of Maryl | - | artment of h | | | giene Reg. No. 20 | 06 375 | 90 |
|-------------|--|------------------|--|---|--|--|---|---------------------------------------|--|---|-----------------|
| | Physici | | Decedent's Name (First, Middle, Late | Tames | Rine | hart | Dodin. | 2. Date of Dea | ath | Year Year Year | agth M |
| | /Medio Examin | | 4a. Facility Name (If not institution, give | street and number) | · pric | 4b. City, Town, o | or Location of Death | 1 | 4c. County of | | |
| | Funeral Director | | 5. Social Security Number 6. S 214-26-1634 Usual Residence of Decedent | ex. 7. Age (In g | yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birt (Month, Da | y, Year) | 9. Birthplace (State or For Country) Mary Jand | preign |
| | Maryland | tor | 10a. State 10b. County Harfo | 100 | City, Town or Lo | exion | \cap | | | 10d. Inside City L | |
| | th with the 23a or 28s | Funeral Director | 10e. Street and Number | St | | 10f. Zip Code | 001 | | 10g. Citizen of W | hat Country? | |
| 36 | is 1 and 2 should be filed within 72 hours after deeth with the Maryland of Heeths and Mental Hygiene. If Heeths and Mental Hygiene. Other Z1e marked other than "natural," or iteme 23s or 28s-f show other traumatic event, its Madical Examinar must be notified at | by Funer | 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Ever Armed Forces? 1 X Yes 2 No I Yes, Give Year or Dates: | 1 | Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No | Hispanic Origin? (S an, Mexican, Puerl Specify: | pecify Yes or No to Rican, etc.) | 14. Race Black Specify: | - American Indian, k, White, etc. | |
| 215-0036 | hin 72 hou e. an "natura Madical E | Completed I | 15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12) | ducation | 16a. Dece (Give life. | dent's Usual Occup kind of work done DO NOT use retire | pation during most of word | rking | 16b. Kind of Bus | siness/Industry | |
| 21 | 2 should be filed within and Mental Hygiene. Ie marked other than aumatic event, the Ma | Be | 17. Father's Name (First, Middle, Last) | | Indi | epende | 18. Mother's Nar | ne (First, Middle, | Maiden Surname | ter. | |
| Maryland | d 2 should h and Men 7 le marke traumatic | 2 | Henry W. Kir 19a. Informant's Name/Relationship (| ICACUTT, Type, Print) | 19b. Mailin | ng Address (Street | and Number or Ru | 4 | 1. 0 | State, Zip Code) | |
| altimore, l | Pages 1 and 3 tent of Heelth nt: If item 27 try or other try | | 20a. Method of Disposition 1 Burial 2 (Cremation 3 5 Other (Specif | Removal from State | - | esition (Name of matory or other pla | CO) A A | Derale | | City or Town, State | |
| Baltir | permit. Page Depertment o important: If eny injury or once. | | 21. Signature of Funeral Service Licer | | anstuke | 2. Name and Addre | PALAL CHA | De F | DREST HI | ILLIND 2105 SERVICES BEI | 50. LAIR |
| | Physician | | 23a. Part1. Enter the disease, or comshock, or heart failure List only Immediate Cause (Final disease or condition | plications that caused the cone cause on each line. | L^{c} . L | ter the mode of dyi | ng, such as cardiad | or respiratory ar | rrest, | Approximate Interval Betwee Onset and Dea | en |
| | /Medical Examiner | | resulting in death) | Due to (or as a con | nsequence of): | | | | | | |
| V | be executed icien and burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | | | | | | | |
| 68760 | y ys | Ilcai | (| . d | | | | | | | |
| B. | death e atter id for u | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. ff yes, outcome of pre 1 ☐ Live birth 2 ☐ ff 4 ☐ Pregnant at time 9 ☐ Unknown | Fetal death 3 | Ectopic pregnanc Other (specify) | у | | 23d. Date Mont | e of delivery th Day Yea | īL |
| | w requires that the s been signed by th should be detache | þ | Part If. Other significant conditions o | ontributing to death but not | t resulting in the u | nderlying cause giv | ven in Part I. | 1 | | bute to the cause of deat | |
| I Rec | The law ele has b | Completed | | | | | | 24a. Was autop perfo 1 Yes | rmerd? de | Vere autopsy findings ava for to completion of caus eath? □ Yes 2 □ No | ulable se of |
| Vita | ysicien: Th is certificete director, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | 04 | | ath (Check only o | ne) | | |
| n of | × 5 5 | on: To | 1 Yes No 27. Manner of Death 1 Natural 5 Pending | 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea | 2 ER/Outpatier 28b. Time of fnjury | f 28c. Inju | | | dence 6 Other | | |
| Divisio | or Attendative death | Certification: | 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined | | At home, farm, str | | Yes 2 □No | 28f. Location (S City or Tow | | r or Rural Route Number | г, |
| _ | Hospitel 24 hours a Funeral etely filled | edical Co | 29a. Certifying Ph (Check only one) Certifying Ph | ysician: To the best of my niner: On the basis of exar and manner stated. | knowledge, deati mination and/or in | h occurred at the ti vestigation, in my o | me, date and place opinion, death occu | a, and due to the curred at the time, | cause(s) and man date and place, ar | iner as stated. Indidue to the cause(s) | |
| | Fo the | Me | 29b. Signature and title of centraler | | | 29c. Licens | se number | | 29d. Date signed | (Month, Day, Year) | |
| _ | 41 | | Da | 1 | 600 | D5 | 4841 | 1 | 1/27/0 | 26 | |
| 2 | TI | | 30. Name and address of person who | completed cause of death | (Item 23a) (Type, | | | 21014 |) | | |
| | Sta Registr | | 31. Date filed (Month, Ray Years) | 2006 ³² . Registrar's S | ignature | Goods! | 11, 100 | | 1 | | |

DHMH 17 Rev 1/2001

06-08703

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Orth A. Rader Certificate of Death Reg No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 15, 2006 1214 hrs Medical Examiner Orth Allen Rader 4a Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Montgomery 3300 N. Leisure World Blvd Silver Spring 8. Date of Birth (MM/DD/YYY) If Under 1 Year If Under 24Hrs. 9. Birthplace (State of 5 Social Security Number 6. Sex Age (In vrs. last birthday) **Funeral** Foreign [/ Country) Washington Months Days Hours Min 579-34-4462 Nov. 15, 1929 Director 77 $_{1}$ X_{M} DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 'n 1 Yes 2 No 28a-f shov MD Montgomery must be notified at once. Silver Spring hours after death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f, Zip Code USA 3330 N. Leisure World Blvd. #908 20906 Funeral 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black 11. Marital Status or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married 2 X Married 2 1 X Yes f Yes, Give Year or Dates: 1947 -Widowed Divorced 1 Yes 2 X No specify: Specify: White ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Department of Health and Mental Hygiene Important: If item 27 is marked other them. Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 4 Director AAA18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oder Rader Viola Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 🕒 👫 19a. Informant's Name/Relationship (Type, Print) 3330 N. Leisure World Blvd. #908 Silver Spring, MD Audrey Rader - Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date crematory or other place) Burial 2 X Cremation 3 Removal from State 11/18/06 Alexandria, VA Metropolitan Crematory Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Altmeyer Funeral Homes 5792 Greenwich Rd. Virginia Bch, Approximate Interval Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and e. List only one cause on each line. /Medical Death a Intra-Oral Gunshot Wound mmediate Cause (Final disease ∹xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical physician a UNPENDED AMENDED Box 68760 IF FEMALE 23d. Date of delivery 23c. If ves. outcome of pregnancy Was decedent pregnant in the 3 Ectopic pregnancy Month Vear Live birth Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ icate has been signed page 2 should be deta \$ ۵. Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes 2 No ✓ Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medica To the Hospital or Attending Physician: Be of Vital examiner? Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other Scene this Inpatient 2 2 ဂ္ 1 🗸 Yes After 28a. Date of Injury FOUND: Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 28b. Time of Injury Certification Subject shot self FOUND: Natural 1 Yes 2 V No 24 hours after death e Funeral Director: Pending filled in by the Nov 15, 2006 1206 hrs Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 3330 N. Leisure World Blvd, Silver Spring, MD determined (Specify) Sport/Athletic Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within 2. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d Date signed (Month Day Year) 29b. Signature and title of certifier 29c. License number November 16, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD.

State Registra

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** John A. Roche 6:20 A^M November 25,2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Parkville Baltimore Co. Oakcrest Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1⊠M 2□F 79 Sept. 04, 1927 Uniontown, PA 189-20-9467 Director Usuel Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a, State ral', or items 23a or 28a-f show Examinar must be extilled at 1 ☐ Yes 2 ☐ No Baltimore Co. MD Parkville Director 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number United States 21234 8810 Walther Blvd.Apt.3205 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", and 2 should be filed within 72 hour alth and Mental Hygiene. 127 Is markad other then "natural ar traumatic event, the Medical Ex 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S.Post Office Letter Carrier 12 n/a 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fil Department of Health and Mental H Important: If item 27 is marked old any injury or other traumatic even 9008. Be Margaret Roth Andrew Roche 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2315 Solgrave Ave.Baltimore,MD 21209 Susan Roche(Daughter) Nov.29, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Timonium, MD. 2006 22. Name and Address of Facility
Evans Funeral Chapel&Cremation Services
9900 Harford Rd. Parkville, MD. 21234
Approximate 21. Signature of Funeral Service L 23a. Part. This tyle disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death JCV month **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe q 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy certificate 1 ☐ Yes 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to nedical examiner? Be Other: 1 ☐ Yes 1 Inpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 2 ☐ ER/Outpatient this 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending in 24 hours after death.
the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completely fi 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner staled. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Par kville mo walth 8100 Toff Mrgral 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 Registrar

DHMH 17 Rev 1/2001

ROCHE JOHN 11/2/106 62

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** DOLORES T. ROBINSON NOVEMBER 21, 2004 Ø2:45F /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days 1 □ M 2 🖫 F 87 220-03-9902 04/21/1920 MARYLAND Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County show "natural", or Items 23a or 28a-f shoved at a contituent at a c 1 ☐ Yes 2 No COCKEYSVILLE Director BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21030 USA 10535 YORK RD Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: WHITE 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) 12yrs College (1-4or 5+) HOMEMAKER HOUSEWIFE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILHELMINA RUSSELL TARLETON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARILYNN HARTING (DAUGHTER) 18916 MIDDLETOWN RD PARKTON, MD. 21120. Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State MORELAND PARK 11/27/2006 PARKVILLE, MD. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MD. 21111. alle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ISCHEMIC CARDIOMYOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to for as a consequence off that the death certificate be executed Exam and -trar Due to (or as a consequence of) physician and the privial-to the purial-to the purial-to the purial-to the purial-to the purial-to the term of the purial-to the term of t Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4□Pregnant at time of death 5 Other (specify) Ö 9□Unknown 9 Unknown σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 1 Yes 3 Probably 4 Unknown PERIPHERAL VASCULAR DISEASE Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an Jas autopsy page pertorme certificate 1∐ Yes 2 Division or Vital 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 TYes 2 □ No within 24 hours after deam.

To the Funeral Director: f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of codifier 101 D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 31. Date filed (Month, Day, Year) 7601 OSLER DRIVE
32: Registrar's Signature M.D. TOWSON, MARYLAND 21204 State Registrar NOV 28 2006

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2006 1:40 P M **Physician** Eunice Kathleen Reynolds /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Adelphi Hillhaven Nursing Home 9. Birthplace (State or Foreign Country) North Dakota If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F Yrs. 2/5/1915 220-40-6239 91 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location il Hygiene. other than "natural", or itams 23a or 28a-f ahov vent, ine Modical Exercitmer coust be notified at 1 Yes 2 No Maryland Prince George's Directo Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with USA 20781 4105 Gallatin Street permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic avant, the Medical section 2000. Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rebecca Marguirite Wheeler Frederick William Hummel ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8-R Plateau Place, Greenbelt, MD Abigail J. Wilcher - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 11/24/2006 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Funerat Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD Much 26a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Years Congestive heart failure /Medical Due to (or as a consequence of) Examiner Years Ischemic cardiomopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X☐ Unknown Acute renal failure Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 🔯 No 26. Place of Death |Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4₺ Nursing Home 5 Residence 6 Other (Specify) Certification; To 3 DOA 1 ☐ Yes 2 X No After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 Pending To the Hospitel or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the funeral completely fi 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier Qualerou, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Anderson ROBYN 10801 LOCKWEDS DRIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 2 8 2006

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Edward Lawerence Robinson

| | | 1- For State | | | Certifica | ate of | Death | | | | R | eg No. | 0.0 | سر يس | the sens area the |
|--|----------------|--|---|---|---------------|---------------------------|---------------------------|---------|---------------------|-------------|-----------------------|---------------|-------------------|-----------------------|---|
| Physicia | | Registrar 1. Decedent's Name (First, Midd | lle,Last) | | - | _ | | | | 2. | Date of Dea | | Year | J U 3 | Time of Death |
| /ledical Exami | ner | Edward Lawren | ce Robins | on | | | | | | | Novembe | r 25, 2 | 006 | | 2153 hrs |
| | | 4a. Facility Name (if not institution | on, give street and n | umber) | _ | 4 | b City, Town | or Lo | ocation of | Death | | | County o | | |
| | | 4223 Kenwood Avenu | ie | | | | Overlea | | | | | | altimore | | <u> </u> |
| Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In y | rs. last birt | hday) | If Under 1 | _ | If Under | _ | 8. Date of B | rth (MM/E | DD/YYYY) | 9. Birthp Foreign | lace (State or |
| Director | | 213-68-3855 | 1 MM 2 F | | 52 | Yrs. | Months [| Days | Hours | Min | Sept. | 4 1 | 954 | Coun | ^{try)} Marylar |
| | ŀ | Usual Residence of Decedent | | | | | | | | | • | | | | |
| any | ı | 10a. State 10b. County | | 10c. | City, Town | or Locatio | n | | | | | | | | 0d Inside City Limits |
| * | اب | MD Balt | imore | | Over: | lea | | | | | | | | , | Yes 2 XNo |
| Aaryland 28a-f show 1 at once. | 쉻 | 10e. Street and Number | | | | | 10f. Zip Coo | е | | | | 10g. Citiz | en of Wh | at Countr | 13 |
| ith the M 23a or 23 notified | Director | 4223 Kenwood | Avenue | | | | 21206 | 5 | | | | U.S. | Α. | | |
| with 1 | | 11. Marital Status | 12. Was De | cedent Ever | n U S | | Decedent of | | | | | D- | | | n Indian, Black, |
| death or item | Funeral | 1 Never Married 2 X | larried Armed I | Forces? | lo | If Ye | s, specify Cu | ban, I | Mexican, | Puerto Ri | ican, etc.) | | White | e, etc. | |
| fter d | | 3 Widowed 4 Di | vorced If Yes, Give Ye | | .0 | 1 | Yes 2 X | No | specify: | | | | Specify: | W | hite |
| ours a | d by | 15. Decedent's Education (Spe | ecify only highest gra | ade complete | | | s Usual Occi | | | | | 16b. K | and of Bus | siness/Ind | ustry |
| 72 hc | Completed | Elementary/Secondary (0-12) | College | (1-4 or 5+) | | | _ | | | 136 1611161 | u) | | 16 0 | | |
| 0036 within 72 jiene ner than " | ш | 12th grade | | | | Home | Improv | | | | | | elf-E | | yed |
| 5-0 led w Hygie othe | | 17. Father's Name (First, Middle | | | | | | | | | irst, Middle, | | | | |
| 21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica | Be | Edward Robins | | | | | | | | | e Agne | | | | |
| AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once | ပ္ | 19a. Informant's Name/Relation | | | | - | Address (S | | | | | | | | |
| e, MD 2 and 2 shou fealth and N item 27 is n | | Esther Robins | on, wire | | | | Kenwo | | | | Dale Date | | ocation - | 212 | |
| ore, M es and 2 of Health of Health If item 2 | | 20a. Method of Disposition 1 X Burial 2 Cremation | n 3 Removal | | cremat | or Disposi tary or oth | tion (Name o er place) | Cerne | | | | | | , | |
| More Pages nent of H nnt: If is | | 4 Donation 5 Other S | | | Garden | | Fait | | - 1 | | | | | | Maryland |
| Baltimore, permit Pages I ar Department of Hee Important: If itei | | 21 Signature of Funeral Service | e Licensee | | - | 22. N | ame and Ado | ress c | of Facility | Mill | er-Dip | pe1 | Fune | ral | Home, Inc. |
| © §9 ™ | 91 g | Mich | 8 | | | 64 | 15 Be: | Lai | r Ro | ad, | Baltin | ore, | MD | 212 | 06 |
| Physician | | 23a. Part I. Enter the diser e. | | caused the d | eath. Do no | ot enter th | e mode of dy | ing, si | uch as ca | rdiac or r | espiratory ar | rest, sho | ick, or hea | art | Approximate Interval Between Onset and |
| /Medical Examiner | | Immediate Cause (Final diseas | | | _ | | | | | | | | | | Death |
| Lxaiiiiiei | | or condition resiting in death) | Due to (or as | a consequer | ce of): | | | | | | | | | | |
| | L | Sequentially list conditions, | b | | | | | | | | | | | - | |
| | Examiner | if any, leading to immediate cause. Enter Underlying Cause | | a consequer | ice of): | | | | | | | | | | |
| , | cam | Disease or injury that initiated events resulting in death) Last | Due to (or as | a consequer | ice otj: | | | | | | | | | | |
| cuted ind transi | | | d | | | - | | | | | | | | | |
| 3760, ficate be executed g physician and s the burial - transi | n/Medical | UNPENDED | AMENDED |) | | | | | | | | | | | |
| Box 68760, e death certificate be the attending physic red for use as the bur | /Me | IF FEMALE: 23b Was decedent pregnant in | 0 | , outcome of | | | | | 1 | | | | Date of | , | |
| 68 certiff | | past 12 months? | 1 | birth gnant at time | - C -I II- | 2 Fet | | 3 | Ectopic | pregnand | су | | Month | Da | y Year |
| eath ceath of attention us | sic | 1 Yes 2 No 9 Ur | aknown | nown | or doddin | 5 Oth | ner (Specify) | | | | | \$ | | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fanneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit | Physicia | Part II. Other significant cond | itions contributing | to death but | not resultin | ng in the u | nderlying cau | se giv | ven in Par | rt I. | 23e. Did | tobacco i | use contri | bute to th | e cause of death? |
| P.C s that gned I | by | | | | | | | | | | 1 Y | es 2 🗸 | No 3 | Probal | oly 4 Unknown |
| 15, quire en sig | ted | | | | | | | | | | 24a. Was | s an | | | psy findings available |
| corr aw re has bo | l de | | | | | | | | | | auto perf | psy ormed? | | rior to cor leath? | npletion of cause of |
| Rec The icate page | Completed | | | | | | | | | | 1 🗸 Yes | 2 N | 0 1 | ✓ Yes | 2 No |
| Division of Vital Records, P.O. rate of a strength of Attending Physician: The law requires that the star death. The law requires that the certificate has been signed by led in by the funeral director, page 2 should be detach | Be (| 25. Was case referred to medic examiner? | Hospital: | 1 | _ | | | | of Death (other | Check or | |] a . | | a a | |
| Physical Physical directions and directions and directions are directions and directions are dir | ု | 1 Yes 2 No | | Inpatient : | | Outpatient Time of Ir | | | at Work | | Home 5 | | nce 6 | | Scene |
| 101 ling l Afte | | 27. Manner of Death 1 Natural 5 Per | Nov 2 | te of Injury hth, Day Year) 5, 2006 | - 1 | 0 hrs | 1]019 | | es 2 | 2 | subject ha | | | eu | |
| Sion Attend death. ector: | ăţi | | estigation | | | | | | | | Of Leasting | /Ctract o | an al Mirana la a | ar av Dusa | L Doute Number City |
| ivis lor A after Dire | Certification: | | uld not be | ace of Injury - | | arm, stree | t, ractory, οπ | ice bu | maing, etc | | or Town, 223 Kenwo | State) | | | Route Number, City |
| Ospital hours noneral y filled | Ö | 4 Homicide | 100000 | y) Single | | | | | | | | | | • | |
| ne Ho n 24 ne Fin | ca | (Check only | Physician: To the b aminer:On the basi | | | | | | | | | | | | |
| To the within To the comple | Medical | | and manner | | | | | _ | number | | | | | | h, Day, Year) |
| 220 00 | 2 | 29b. Signature and title of certif | 0 1 | 000 | 0 | | | .C.N | | | | | ember | | |
| | ĺ | laro | L 44 | UL | MI | _ | -+ " | | | | | 1,400 | SITIDEI | _0, _00 | |
| 1 | | 30 Name and address of person | | | | Don- (| Stroot De | tim- | ro MD | 21204 | | | | | |
| 0 | | | ssistant Medica | | | renn S | Street, Ba | LIKTIO | ie, MD | 21201 | | | | | |
| | tate | | 7) 32, | Registrar's Si | gnature | A. a. A | P 10 | | | | | | | | |
| Regis | | NOV 2 8 | 2006 July | idea o the | 450 | | | | | | | | | | |
| Drivin 17 Rev 17 | ZUUT | | <i>A</i> | | OF | RIGINA | L | | | | | | | | |

Drivin 17 Rev 1/2001 OCME 2006

| | | | 1 - For State Registrar | State o | f Maryland | | artment rtificate | | | and M | | jiene eg. No. 2 | 006 | 37 | 596 |
|----------------------------|--|----------------|---|---|---|-------------------------|------------------------------|------------------------|----------------------------|--------------------------|--|----------------------------|-----------------------------|--|-------------------------|
| Ш | Physici | an | 1. Decedent's Name (First, Middle | , Last) | | | | | | | 2. Date of Dea Month | th Day | Year | 3. Time | of Death |
| | /Medic | | Blanche L. Seed | | | | | | | - | Novembe | r 11, | 2006 | | PM M |
| 1 | Examir | er | 4a. Facility Name (If not institution, | | mber) | | | | Location o | of Death | | | ounty of Dea | | |
| | | | 16 N. Knollside | E Lane | 7. Age (In yrs. last | highday | M10 | | town | 24 Hrs | 8. Date of Birth | 1 | reder | | o or Foreign |
| | Funeral Director | | 476-12-2892 | 1 □ M 2 ☑ F | 85 | Yrs. | Months | Days | Hours | Min. | (Month, Day Nov 28, | Year) | Co | thplace (Stat ou <i>ntry)</i> nnesot | |
| | | | Usual Residence of Decedent | | 0.5 | | | | | | NOV 20, | 1720 | , , , , , | mesoc | · a |
| | how | | 10a. State 10b. County | | 10c. City, T | own or Lo | cation | | | | | | | | City Limits |
| | Ba-1- | cto | | erick | Mi | ldd1e | town | | | | | | | 1 D Y | es 2√No |
| | الله الله الله الله الله الله الله الله | Director | 10e. Street and Number | | | | 10f. Zip | Code | | | 1 | 0g. Citizer | n of What Co | ountry? | |
| | s 23e | ral | 16 N. Knollside | | -t15 | 10.1 | Was Board | 217 | | -:-0 /0 | | 144 | USA | was badia | |
| | Her de | Funeral | 11. Marital Status 1 □ Never Married 2 □ Marrie | Armed Fo | | 13. | was Deced If Yes, spec | ify Cuba | n, Mexican | gin? (Spe i, Puerto | ecify Yes or No- Rican, etc.) | 14. | Black, Whit | erican Indian, te, etc. | |
| 99 | Ir, or | ρ | 3 ☐ Widowed 4 ☑ Divorced | If Yes, Gir Year or D | ve lates: | | 1□Yes 2 | No X | Specify: | | | Sp | ресіfy: wh | ite | |
| Š | filed within 72 hours after death with the Maryland Hygiene. the than "naturel", or Items 23a or 28a-f ehow ent, the Medical Examinat must be notified at | Completed | 15. Decedent | 's Education | 1 | 6a. Dece | dent's Usua | I Occupa | ition | المام المام المام | unk | 16b. Kind | of Business | /Industry | |
| 2 | thin 7 | nple | (Specify only highest Elementary/Secondary (0-12) | College (| 1-4or 5+) | life. | kind of wor DO NOT us | e retired, |) | OF WORKS | ng | | | | |
| 7 | filed wi Hygien ther th | | 12 | 0 | | | | • | | | | | | ervice | |
| D Bu | be fil htal H bd off | Be | 17. Father's Name (First, Middle, L | .ast) | | | u: | nk | 18. Mothe | r's Name | (First, Middle, i | <i>Maiden S</i> u | mame) | | unk |
| Maryland 21215-0036 | s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene if them 27 is marked other than "naturel", or items 23a or 28a-1 show item 27 is marked other than "naturel", or items and the notified at other traumatic event, the Medical Examinar must be notified at | P | 19a. Informant's Name/Relationsh | in (Tuna Print) | | 10b Mailie | a Addross | (Street o | and Alumba | r or Our | J Pouto Numbo | City or T | Ctata | Zin Code) | |
| Σa | id 2 s Ith an 27 is i | | Nancy CLark/dau | | | | | | | | I Route Number | | | | |
| | permit. Pages 1 end 2. Depertment of Health at Importent: If item 27 is any injury or other trat | | 20a. Method of Disposition | giitei | 20b. Place | e of Dispo | sition (Nam | ne of | | | ersvill Date | | | Town, State | |
| Ë | Pages nent of P ent: If ite ury or of | | 1 ☐ Burial 2 ☐ Cremation 4 🔯 Donation 5 ☐ Other (Sp | | State | өтөгү, сгөг | natory or ot | mer place | 9) | | | | | | |
| Baltimore, | permit. I Depertm Importer any injur | | 21. Signature of Funeral Service L | | | C ²² | . Name an | d Addres | s of Faculit | Xand | 655 W. | Do1+- | imara | Ctroot | |
| Ö | Depending of the poor of the p | | Konard S | wade, | rector | | ltimo | | | 21201 | L COO W. | ватт. | IMOLE | Street | - 1 |
| | | | 23a. Per 1. Enter the disease, or shock, or heart failure. List of | complications that conly one cause on e | caused the death. (| Do not ent | er the mode | e of dying | g, such as | cardiac o | r respiratory arr | est, | | Approxim Interval E | |
| | Physician | | Immediate Cause (Final disease or condition | | Se | nile | Dei | men | tia | | | | | Onset an | |
| | /Medical Examiner | | resulting in death) | Due to | (or as a consequen | ice of): | | | | | | | | 700 | v • J |
| Н | LAGITIFIE | | Sequentially list conditions, | b. ——— | | | | | | | | | | | |
| | led Isit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to | (or as a consequen | ice ut). | | | | | | | | | |
| | sxecu s end al-trai | хаг | that initiated events resulting in death) Last | c. Due to | (or as a consequen | ice of): | | | | | | | | | |
| 8760, | The law requires that the death certificate be executed tie hes been signed by the attending physicien end bage 2 should be detached for use as the burial-transit | dical [| | 4 | | | | | | | | | | | |
| 9 | tificat ig phy as th | led | | | | | | | | | | | | | |
| P.O. Box | th cer tendir r use | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | | tcome of pregnancy birth 2 D Fetal de | | Ectopic pre | egnancy | | | | 23d | d. Date of de | | |
| | b dea | sicia | in the past 12 months? 1 ☐ Yes 2 ☑ No | | ant at time of death | | Other (spe | | | | | | Month | Day | Year |
| <u>م</u> | d by t detach | Phy | 9 Unknown | | | - t- 11 | | | - 1- 01 | | non Biday | | | | |
| Division of Vital Records, | signe | þ | Part II. Other significant condition HXNCN +C | | eath but not resultin | ig in the u | nderlying ca | ause give | n in Part I. | | 1 \(\) Ye | ~ | | the cause of the c | |
| Š | been shoulk | Completed by | (// () | | | | | | | _ | | - | | | |
| Be | | шb | | | - | | | | | | 24a. Was a autops perform | y | prior to death? | utopsy finding completion o | s available cause of |
| a | Physician: The la r this certificate hes ral director, page 2 | ပိ | 25. Was case referred to medical | | | | | | 00 84 | 15 | 1 ☐ Yes | 2 No | 1 🗆 Yes | 2 □ No | |
| > | rsicia s cert direct | To B | examiner? | Hospital: | Inpatient 2 ☐ ER | /Outpatier | t 3 🗆 DO | Othe | | | ne 5 Reside | | Other (See | c.fs.() | |
| ō | Attending Physician: or death. ector: After this certifice by the funeral director. | ī.ī | 27. Manner of Death | 28a. Date | | b. Time of | | 8c. Injury Work | at | | 28d. Describe ho | | | cny) | |
| Ö | endin ath. or: Afr | atlo | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig | ation | in, Day real) | піцагу | М | | es 2 🗆 f | No | | | | | |
| Σį | r Atte | Certification; | 3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determine | ned 288. Place | of Injury - At home ng, etc. (Specify) | , farm, str | eet, factory | , office | | - | 28f. Location (St City or Town | reet and N | lumber or Ri | ural Route N | ımber, |
| Ω | urs af | | | | | | | | | | | | | | |
| | To the Hospital or Attending Ph within 24 hours after death to the Funeral Director: After th completely filled in by the funeral | edical | 29a. Certifier 1 Certifying (Check only 2 Medical E | Physician: To the xaminer: On the b | asis of examination | dge, death and/or in | n occurred a vestigation, | at the tim in my op | e, date and inion, deat | d place, a th occurre | and due to the ca ed at the time, d | ause(s) and ate and pla | d manner as ace, and due | s stated. to the cause | e(s) |
| | ithin 2 | Med | 29b. Signature and title of certifier | and man | ner stated. | | 29c | . License | number | | 2 | 9d. Date s | ianed (Mont | h, Day, Year |) |
| | F 3 F 8 | | 1-2/Gl | an 1 | 10 | | | Philippe . | | 03 | 7 | 11 | 115/2 | 006 | |
| | | | 30. Name and address of person v | who completed caus | se of death (Item 23 | Ba) (Type | Print) | | | | | • 1 | 1131 | | |
| | | | | h Avenu | | -41 | wick | (| MD | | 2171 | 6 | | | |
| | Sta | | 31. Date filed (Month. Day, Year) | 32.5 | legistrar's Signature | A | NOVE S | ? | | | | | | | |
| | Registr | ar | NOV 2 8 | S ZUUD A | The said of the said | 27 | | | | | | | | | |

| | | For State Registrar | | | State | of Mar | yland | / Depa | | nt of H | | | /lent | | giene Reg. No | 201 | 06 | 3759 |
|---|---------------------|--|--------------------------------------|---------------|-------------------------|--------------------------|------------|-----------------------------|-----------------|---|------------------|------------|---------|-------------|------------------|-----------|-----------------------|--|
| y. | | Decedent's Nam | ne (First, Middle | e, Last) | | | | | | | | | | ate of Dea | ath | | - W | 3. Time of Death |
| Physicia /Medic | | Fran | | J | | | ikora | a | | | | | | v. 2 | 3, 2 | 006 | Year | 6:20 AM |
| Examin | er | 4a. Facility Name (| | | | | o 30 | | | , Town, or apoli | | of Death | | | | | of Death | do1 |
| | | | Arunde1 | 6. Sex | ıcaı | | | t binthday) | | aporr | S If Under | 24 Hrs | 9 D | ate of Birt | | me | Arun | |
| Funeral Director | | 5. Social Security I 019-16- | | | / 2□ F | 7. Age (| | Yrs. | Months | | Hours | Min. | (N | nonth Da | y, Year) | | | place (State or Foreig ntry) sachusett: |
| р , | | Usual Residence | , | | | | Oo Ciby | Town or Lo | ontion | | | | | | | | | 10d. Inside City Limits |
| aryia shov | _ | 10a. State | 10b. County | | | | | | Cation | | | | | | | | | 1 ☐ Yes 2 ☐ No |
| 8a-f | 5 | MD | Anne | Arun | del | | Arno | old | 1.04 7 | | | | | | 40- 07 | · 1 | A/b = A C = | Λ. |
| vith ti | 吉 | 10e. Street and Nu | | | | | | | | ip Code | | | | | | | Vhat Cou | ntry : |
| 230 | ra | 433 Kin | gs Coll | | | | :- II C | 10.1 | | 1012 edent of Hi | i- Ori | inin2 (Cn | and v | /aa as Na | US. | | o - Amori | can Indian, |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Inspertment of Health and Mental Hygiene. Inspertment: if item 27 is marked other than "natural", or Itame 23a or 28a-f show any injury or other traumatic avent, the Medical Exam an investical colling at once. | by Funeral Director | _ | rried 2 Mari | bein | Armed F | 2 🗆 No | ermo.s. | | f Yes, sp | ecify Cubai | Specify: | n, Puerto | Rican | i, etc.) | | | k, White, | |
| 72 hour | | | 15. Deceden | t's Educa | ition | | | 16a. Dece | kind of w | ual Occupa ork done d use retired | turing mos | st of work | aing | | 16b. K | ind of Bu | usiness/In | ndustry |
| d within giene. | Completed | Elementary/Sec 11 | ondary (0-12) | | College | (1-4or 5+) | | | ctri | | <i>-</i> | | | | Bu | ildi | ng M | aintenance |
| of file | Bec | 17. Father's Name | | Last) | | | | | | | 18. Moth | er's Nam | e (Firs | t, Middle, | Maiden | Suman | ne) | |
| Ment Ment Ment Ment Ment Ment Ment Ment | 2 | Thomas | Sikora | | | | | | | | Kath | nerin | ne l | Bies | | | | |
| sho and I | | 19a. Informant's N | Name/Relations | hip (Type | e, Print) | | | 19b. Mailin | ng Addre | ss (Street a | and Numb | er or Rur | ral Rou | ite Numbe | er, City o | or Town, | State, Zip | o Code) |
| and and n 27 | ļ | Karen A | . Fishe | r -] | Daugh | | | | | s Co. | | | | rno1c | _ | | | |
| of Ho | | 20a. Method of Dis | sposition 2 Cremation | 3 □Ber | moval fron | n State | | ce of Dispo netery, crea | | | | | Date | | 20c. L | ocation - | City or T | own, State |
| Pag ment ent: ury c | | | 5 Other (S | | | | Mair | n Str | | | | | | | | | у, М | |
| permit. Depart Import any inj | | 21. Signature of F | Funeral Service | Licensee | · | ı On | | | | | | | | | | | | eral Home |
| # 5 E # 3 | | THE | lend | | Le | dx | | | | | | | | | | , Ma | ssac | husetts |
| | | 23a. Parti. Enter shock, or he | the disease, or art failure. List | only one | ations that cause on | caused the each line. | ne death. | Do not ent | er the m | ode of dying | g, such as | cardiac | or resp | piratory a | rrest, | | | Approximate Interval Between Onset and Death |
| Physician | | Immediate l'ause disease or conditi | ion | | B | Fac | iste | en | 54 | roke | _ | | | | | | | Onset and Death |
| /Medical | | resulting in death |) | | Due to | o (or as a | conseque | nce of): | | | | | | | | | | |
| Examiner | | Sequentially list of | onditions. | b. | | | | | | | | | | | | | | |
| ₽ \V = | Examiner | Sequentially list of any, leading to it cause. Enter Und Cause Disease of the cause | immediate derlying | Į | Due to | o (or as a o | conseque | nce of): | | | | | | | | | | |
| be executed sicien and burial-transit | cam | that initiated even resulting in death) | 15 | С. | Dug to | o (or as a o | 200000000 | noo of): | | | | | | | | | | |
| ate be ex hysicien the burial | | 3 | | | D00 11 | 0 (01 83 8 1 | 201130400 | 1100 01). | | | | | | | | | | |
| cate ohys | dicai | | | d. | | | | | | | | - | | | | | | |
| The taw requires that the death certificate has been signed by the attending page 2 should be detached for use as | Physician/Me | IF FEMALE: | | 236 | c. If ves. o | utcome of | pregnanc | ev e | | | | | | | | 22d Day | to of dolin | 1004 |
| atten for us | ian | 23b. Was decede in the past 1: | 2 months? | | 1 Live | birth 2 | Fetal d | eath 3[| Ectopic Other (| pregnancy | | | | | | | te of deliv Inth | Day Year |
| he de | ysic | 1 □ Yes 2 9 □ Unknow | | | 9□ Unk | | 110 01 000 | 5 |) 101110 [| specify | | | | | | | | |
| thet the de ed by the detached | | Part II. Other sign | ificant conditi | ons contr | nbuting to | death but | not result | ing in the u | nderlying | cause give | en in Part | l. | 2 | 23e. Did t | obacco | use cont | ribute to t | the cause of death? |
| sign d be | d b | (4) | Con | 12 | CF | لاصام | (*) | | | | | | | 1 🗆 ` | Yes 2 | □No | 3 Pro | bably 4 Unknow |
| w requires thets been signed to should be det | ete | - | , | | | | | | | | | | - | 24a. Was | 20 | 24h | Wara aut | opsy findings available |
| has ge 2 | Completed | | | | | | | | | | | | 1 | autor | | | prior to co death? | empletion of cause of |
| | | 05 111 | | | | | | | | | | | | Yes | 2 Alc | · | 1 🗆 Yes | 2□ No |
| Attending Physician: r death. ector: After this certifics by the funeral director. | Be C | 25. Was case references | | - | spital: | 7 | | D/O | | Othe | 0.5 | | | eck only o | | | | |
| Phys rat di | 10 | 1 Yes 2 | | | | Inpatient e of Injury | | R/Outpatier | | 28c. Injury | 4 🗀 141 | ursing Ho | | 5 Reside | | | | ny) |
| ding h. Afte fune | ë | 1 Alatural | 5 Pendi | ng igation | (Mc | onth, Day Y | | Injury | M | Work | k? `` Yes 2 □ | lNo | | | | , | | |
| deatl deatl ctor: y the | ficat | 2 ☐ Accident 3 ☐ Suicide | 6 ☐ Could | not be | 28e Plac | ce of Injury | v - At hom | ne, farm, st | | | | | 28f. L | ocation (| Street a | nd Numb | er or Rur | al Route Number, |
| ital or A | Certification: | 4 🗌 Homicide | determ | nirieu | buil | lding, etc. | (Specify) | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | City or To | wn, State | θ) | | |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director. | Medical | 29a. Certifier (Check only one) | 1 ☑ Certifyi 2 ☐ Medical | | er: On the | | xaminatio | | | | | | | | | | | stated. to the cause(s) |
| To the vithing To to | Σ | 29b. Signature an | nd title of certifie | er | | | | | 2 | 9c. License | e number | | | | | , | | Dey, Year) |
| 1 | | * | | (| 2 | | 11. ~ | | | 061 | 1829 | | | | W | 123/ | 1200 | 6 |
| h | | 30. Name and a | dress of person | who com | | | | | | | | | | | | | | |
| | | Regnal | do Le | e-L | lace | · IP | 41) | 210 | 43 | mark | D | (Ve | C | Lest | - | MS | 21 | 609 |
| Sta | | 31. Date filed (Mo | onth, Day, Year |) | 32 | Registrar | 's Signatu | 210 re | Afr | | -0 | | / | | | | | |
| Registr | ar | | NOV 2 9 | 3 200 | 6 1 | Milds. | 0 13 | A ST | | | | | | | | | | |
| HMH 17 Rev 1/2 | 001 | | 10 PA 2. W. | - 1,000 | 1 | | | 6 | | | | | | | | | | |

DHMH 17 Rev 1/2001

| | | | 1 - For State Registrar | State of Maryla | | | of Health of Deatl | | | giene | 006 | 37598 |
|-------------------------------------|---|------------------|---|---|---|--------------------------------|--|----------------------------|--|-----------------------------|-----------------------------|--|
| | Dhusiai | - | 1. Decedent's Name (First, Middle, Last) | | | | | | 2. Date of Dea Month | th Day | Year , | 3. Time of Death |
| | Physici /Medi | | Dennis Michae | | | | | | _[/ | 23 | 2006 | 5:40 AM |
| | Examir | ner | 4a. Facility Name (If not institution, give s | | Lai | 4b. City, To | own, or Location | n of Death | | | inty of Death | 20 . 60 |
| | | - | 5. Social Security Number Sex | are HOSPI | . last birthday) | If Under 1 | Year If Unde | er 24 Hrs. | 8 Date of Birth | | altic | nore (State or Foreign |
| | Funeral Director | | | M 2□F | 56 Yrs. | | Days Hours | Min. | 8. Date of Birth (Month, Day 3 / 1 7 / 1 | 950 | | lace (State or Foreign try) 1sylvania |
| 1 | 2 | | Usual Residence of Decedent | 140.70 | | | | | 37 1 7 7 1 | | | |
| | ehow | 2 | 10a. State 10b. County MD Baltimor | | ity, Town or Loc Perry | | | | | | 1 | 0d. Inside City Limits 1 ☐ Yes 2X No |
| | the M | ecto | 10e. Street and Number | . e | rerry | | | | | IO- Citi | -4.14/51-0 | |
| () | 72 hours after death with the Maryland natural', or itema 23e or 28e-f ehow disal Examiner musi be inclifted at | Funeral Director | 5210 Cobbler | Ct | | 10f. Zip C | 21128 | | | _ | of What Coun USA | try? |
| | death ma 23 | era | | 2. Was Decedent Ever in | J.S. 13. V | | | Origin? (Spec | cify Yes or No- | | Race - Americ | an Indian, |
| 2 | after or ite | Ξ | 1 Never Married XXMarried | Armed Forces? 1 ☐ Yes 2 No | | 17 | | | tican, etc.) | | Black, White, | |
| 33 | ural, | d by | 3 Widowed 4 Divorced | If Yes, Give Year or Dates: | <u>'</u> | ☐ Yes X | XNo Specif | y: | | Spe | ecify: whi | te |
| 5. | "natu | Completed | 15. Decedent's Educ (Specify only highest grade | | 16a. Deced | ent's Usual C | Occupation done during mo retired) | ost of workin | g | 16b. Kind o | f Business/Ind | dustry |
| 7 2 2 | within ene. then " | dmc | Elementary/Secondary (0-12) | College (1-4or 5+) 5 + | | | 1 educ | | | Pub | lic Sc | chools |
| Q 2 | filed Hygi other | Be Co | 17. Father's Name (First, Middle, Last) | <u> </u> | | , CO _ C | | | (First, Middle, | | | |
| lan le | Aental Aental rked | To B | Richard Snyder | : | | | | Peg | gy Far | mer | | |
| Nder, Der Maryland 21215-0036 | and Men le marke | | 19a. Informant's Name/Relationship (Typ | | | | | | Route Number | - | | |
| - | Health Health tem 27 I | | Denise Snyder | | | | | | Perry | Hall | , MD 2 | 21128 |
| Saltimore | Jes 1 t of H if iter or oth | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re | 20b. emoval from State | Place of Dispos cometery, cram rans Fi lapel-I | sition (Name natory or othe | of place) | Nove | mber 2006 | | on - City or To | |
| ţ, | tment tant: | | 4 □ Donation 5 □ Other (Specify) | | | | | | | | | 11,MD |
| Ba | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or itema 23e or 28a-f ehow early injury or other traumatic event, Ite Medical Eventual be routined and once. | | 21. Signature of Funeral Service Dicent | L. | And | Vans d Cre | Address of Fac Funera Mation | Cha Serv | apel vices | Park | Ville, | ord Rd. 21234 |
| | | | 23al Part1. Enter the disease, or complice shock, or heart failure. List only one | e cause on each line. | th. Do not ente | er the mode o | of dying, such a | is cardiac or | respiratory arr | est, | | Approximate Interval Between Onset and Death |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | Hyperco | ucem | ia | | | | | | Onset and Death |
| | /Medical Examiner | | Tooding in deality | Due lo (or as a conse | quence of): | 010 == | . 011 00 0 | E II. | ak = | | | |
| | | e. | Sequentially list conditions, if any, leading to immediate | Due to (or as a conse | quence of): | ocure | Mome | _01 W | nknown | Pri | nary | |
| 1118 | uted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | |
| 0,0 | ite be executed iysicien and ne burial-transit | Еха | resulting in death) Last | Due to (or as a conse | quence of): | | | | | | | |
| 3760, | ate be ex hysicien the buria | lical | d. | | | | | | | | | |
| 89 x | Attending Physicien: The law requires that the death certifics rideath. If death. ector: After this certificate hes been signed by the attending priby the funeral director, page 2 should be detached for use as it by the tuneral director. | Physician/Med | IF FEMALE: | L # 50 | | | | | | | | |
| Bo | attend for us | lan/ | 23b. Was decedent pregnant in the past 12 months? | 3c. If yes, outcome of pregr | al death 3 🗌 | Ectopic preg | | | | 1 | Date of delive Month | ry Day Year |
| o. | that the de ned by the a detached f | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Pregnant at time of 9□Unknown | death 5 | Other (speci | rfy) | | | | | |
| Division of Vital Records, P.O. Box | igned by be deta | by Ph | Part II. Other significent conditions conf | ributing to death but not re | sulting in the un | derlying caus | se given in Part | t I. | 23e. Did tol | bacco use c | ontribute to th | e cause of death? |
| rds | w requires been sign should be | ed b | | · · · · · · · · · · · · · · · · · · · | | | | | 1 🗆 Ye | es 2 No | 3 Proba | ably 4 Dunknown |
| ပ္တ | aw requise been 2 should | Completed | | | | | | | 24a. Was a | | b. Were autop | osy findings available |
| <u>~</u> | The I | Com | | | | | | | autops perforr | med? | death? | opletion of cause of |
| /ita | or Attending Physicien: The lav after death. Director: After this certificate hes in by the funeral director, page 2 | Be | 25. Was case referred to medical examiner? | | | | | ce of Death | Check only on | | | |
|) (| hysic this c | ို | 1 ☐ Yes 2 ☑ No | | ER/Outpatient | | | | e 5 ☐ Reside | | |) |
| u C | ding F | i.i. | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. | . Injury at Work? | | 3d. Describe ha | ow injury occ | curred | |
| isi | Mttend death ctor: / y the f | ficat | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | 28e. Place of Injury - At I | nome farm stre | | 1 Yes 2 | | ocation (St | reet and Nu | mber or Rural | Route Number, |
| Ο̈́ | after after Dire | Certification; | 4 Homicide determined | building, etc. (Spec | ify) | ot, radioty, d | ,,,,, | | City or Town | n, State) | or or rearer | ricale (valida), |
| \bigcirc | To the Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fu | Medical C | 29a. Certifier Check only one) | ician: To the best of my kn er: On the basis of examin and manner stated. | owledge, death ation and/or inv | occurred at lestigation, in | the time, date a my opinion, de | and place, areath occurred | nd due to the ca | ause(s) and ate and plac | manner as state, and due to | ated. the cause(s) |
| | To the within To the comple | Me | 29b. Signature and title of certifier | // // | | 29c. L | icense number | | 2 | 9d. Date sig | ned (Month, L | Day, Year) |
| | ->-0 | | V/J | 1// | | 13 | 0060 | 45 | A | 1000 | 1 - | 7 7 2 2 2 2 2 |
| | 10 | | 30. National address of person who con | npleted cause of death (Ite | m 23a) (Type, F | Print) | 000 | 77> | / | OVEN | nop/ d | 3 2006 |
| 8 | 100 | | Dr. Anastasios | Saliaris | , 900 | 0 Fr | anklin | nSqu | are Dr | ive | Balto. | 13 2006 MD 21237 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 32 Registrar's Sign | ature | and D | | l - | | | | |

| | | 1 - For State Registrar | State of Mary | - | artment of F | | | giene Reg. No 2 0 (| 16 37599 |
|--|-------------------|---|--|--|---|---|--|------------------------|--|
| Physic | | 1. Decedent's Name (First, Middle, Last) | NCIS GERO | | | | 2. Date of De Month | | 3. Time of Death Year 2006 10:15 |
| /Med Exam | | 4a. Facility Name (If not institution, give : MANOR CARE RUX | street and number) | | | r Location of Death | 110 V 21. | 4c. County | |
| Funera Director | | 2.0 12 1775 2 | 7. Age (In | yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bird (Month, Da 5-22, | th y, Year) | Birthplece (State or Foreign Country) MARYLAND |
| faryland show | ٥ | Usual Residence of Decedent | | c. City, Town or Lo | cation | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No |
| with the N a or 28a-f | Director | 10e. Street and Number 7001 N. CHARLES | | TOWSON | 10f. Zip Code | 4004 | | 10g. Citizen of W | |
| 5-0036 72 hours after death with the Maryland natural; or Items 23s or 28s-f show clear Examine must be notilized at | by Funeral | | 12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | 1 | | 1204 ispanic Origin? (Spe an, Mexican, Puerto Specify: | ecity Yes or No Rican, etc.) | | e - American Indian, k, White, etc. WHITE |
| IOCE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylan st of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event, the Medical Examinar must be notified at | Completed | 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) UNKNOWN | cation | (Give life. I | dent's Usual Occup kind of work done o DO NOT use retired | during most of worki | ng | 16b. Kind of Bu | |
| Maryland Id 2 should be file th and Mental Hy 27 is marked oth traumatic event | To Be (| 17. Father's Name (First, Middle, Last) JOHN FRANCIS S | | | | 18. Mother's Name | | Maiden Surname | 9) |
| e, Mar 1 and 2 sh 1 dealth and 1 m 27 1s m | 1.3 | 19a. Informant's Name/Relationship (Ty, JOHN H. STEINM 20a. Method of Disposition | ETZ-Brothe | | TIMOTH | | | INSTER, | MD21157 |
| Baltimore, permit. Pages 1 a Department of He Importent: If Item any injury or othe once. | | 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of uneral Service Licens | emoval from State | cemetery, cren WOODLAW | natory or other place N CEMET | ERY 11-2 | 25-200 | BALT | City or Town, State CIMORE, MD NIUM, MD 2109 CAL AND CREM. |
| S8760, Cate be executed Medical Examiner physician and subspace subspace in the burial-transit | dicai Examiner | 23a. Part1. Enter the disease, or compile shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a co | death. Do not enti- structure of): diam nsequence of): | Hear Hear Yo Pat | g, such as cardiac o | r respiratory ar | rest, | Approximate Interval Between Onset and Death |
| Box 6 ath certifi | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown | Fetel death 3 | Ectopic pregnancy Other (specify) | | 3333 | 23d. Date Mon | of delivery th Day Year |
| cords, P.O. I | b | Part II. Other significant conditions con | tributing to death but no | t resulting in the ur | iderlying cause give | en in Part I. | m _ | | bute to the cause of death? 3 Probably 4 Unknown |
| Vital Records, slotan: The law requires to certificate has been signe rector, page 2 should be | Completed | | | | | | 24a. Was autop perfor 1 Yes | rmed? de | fere autopsy findings available for to completion of cause of eath? ☐ Yes 2 ☒ No |
| f Vital F ysician: Th is certificate director, pag | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No | ospital: | 2 ER/Outpatien | 3 DOA Othe | 26. Place of Death | 100 | ne) lence 6 ⊟Othe | |
| Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate in completely filled in by the funeral director, page | Certification: T | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | 28a. Date of Injury (Month, Day Yea 28e. Place of Injury- building, etc. (S) | 28b. Time of Injury At home, farm, stre | 28c. Injury Work M 1 🗀 Y | y at 2 (? Yes 2 □ No | 8d. Describe h | ow injury occurre | |
| To the Hospital of within 24 hours af To the Funeral D completely filled in | edicai Cei | Check only 2 Medical Examin | ician: To the best of my er: On the basis of exa | knowledge, death | occurred at the timestigation, in my op | e, date and place, a | and due to the o | ause(s) and man | ner as stated. |
| To the within 2 To the comple | Med | 29b. Signature and title of certifier | and manner stated. | Do. | 29c. License | | 2 | 29d. Date signed | (Month, Day, Year) |
| 1 | | 30. Name and address of person who con Cyrus Asadi, | 20E.T. | moniur | | | | | |
| Regist | | 31. Date filed (Month, Day, Year) | 32. Rasistrar's S | Signature | sell o | | | | |
| DHMH 17 Rev 1/3 | 2001 | | The state of the s | ORIGIN | AL | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 21,2006 Staggers guember /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Conte 100 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□F Months Days Hours Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Baltimore Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21211 Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Specify: Armu 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by 4 Divorced 3 Widowed black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) eache Himore Cite 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. 20b. Place of Disposition (Name of cemetery, crematory or other place) Oora Staggers eithldaunk Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Voughn C. Greene funeral Service 21. Signature of Funeral Service Licensee 721 liberty Rd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Randallstown, mD 21133 Approximate Interval Between Onset and Death Immediate Cause (Final ens Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 DEctopic pregnancy Year Month Day 5 ☐ Other (specify) ☐Yes 2☐No Division or Vital Records, P.O. the detached 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 1 Yes 2 No 4 □ Nursing Home 5 □ Residence 6 ▶ Oother (Specify) NOSPI 4 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this within 24 hours and To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation Injury Hospital or Attending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29b. Signature and title of certifier 22 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Charles St Tonson M CHARLUS MO

State Registrar 31. Date filed (Month, Day, Year)

NOV 2

8 2006 6365

32. Registrar's Signature

Please Type or Print in Black Indelible Ink

| obert L. Speller | | Sta 1- For State | ate of Maryland | • | artment of | | and | Menta | al Hygie | | 0.0 | | |
|---|----------------|---|--|-------------------|--------------------|----------------------|-----------|-------------------------------|---------------------------|---------------------|-------------------------------|------------------|---|
| Physicia | | Registrar 1. Decedent's Name (First, Middle | Last) | | timouto or . | | | | 2. D | Reg ate of Death | . No. |) U (| Time of Death 5 |
| Medical Exami | | ROBERT LOUIS | SPELLER | | | | | | N | ovember | | | 1830 hrs |
| | | 4a Facility Name (if not institution 1732 Poplar Grove Apr | | r) | 44 | City, Tow Baltimo | | ocation of I | Death | | 4c. County of | | |
| · | | | | go (In yes, I | ast birthday) | If Under | | If Under 2 | 24Ure B | Date of Birth | N/A | | nlace (State or |
| Funeral Director | | | | ige (iii yi s. ii | | Months | Days | Hours | Min. | | ` | F0-01-0 | |
| Sirosto. | | 239-60-0208 Usual Residence of Decedent | 1 X M 2 F | 68 | Yrs. | | | | | 5-23-1 | 1938 | Coul | ntry) N.C. |
| any | ı | 10a State 10b. County | | 10c. City, | Town or Locatio | n | | | | - | | | 10d. Inside City Limits |
| | اءِ | MD. N/A | | BA | LTIMORE | | | | | | | | 1 XYes 2 No |
| Maryland 28a-f show d at once. | Director | 10e Street and Number | | | | 10f. Zip Co | ode | | | 10g | . Citizen of Wha | t Count | ry? |
| ith the Maryland 23a or 28a-f sho notified at once | 吉 | 1732 POPLAR | GROVE | | | | 2121 | 16 | | | USA | | |
| ms 2. | uneral | 11. Marital Status | 12. Was Deceder Armed Forces | | | | | | ? (Specify uerto Rica | Yes or No- | 14. Race - White, | | an Indian, Black, |
| r death w or items must be | F. | | 1 Yes 2 | 2 x No | | | | | dorto Mod | , 0.0.7 | | | |
| s afte rral". | 2 | | orced If Yes, Give Year or Dates: | amminted) | 1 16a. Decedent | res 2 X | - | | od of work | dono II | Specify B | | |
| hour "natu | ted | 15. Decedent's Education (Spec Elementary/Secondary (0-12) | College (1-4 or | | during mos | | | | | Jone | IOD. KING OF BUSI | nessin | dustry |
| 21215-0036 uid be filed within 72 hours after Mental Hygiene marked other than "natural", c event, the Medical Examiner | Completed | -12- | -0- | , , | SUP | ERVIS | OR | | | | GUAL | TNE | Y |
| 21215-0036 Juld be filed within 7 Mental Hygiene marked other than | 녌 | 17 Father's Name (First, Middle, | Last) | | | | | .Mother's | Name (Firs | st, Middle, Ma | iden Surname) | | |
| 218 be fill ntal H rked | Be | BRODIE SPELL | ER | | | | | | | GILLIA | | | |
| MD 21215-0036 2 should be fifed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she imatic event, the Medical Examiner must be notified at once | ٩ | 19a Informant's Name/Relationsh DEBORIA SPED | IIP (Type, Print) LER CREECY | • | 19b. Mailing 403 | Address (| Street a | and Number $\Gamma_ullet\ WI$ | er or Rural NDSOR | Route Number | er, City or Town, CH CAROL | State, INA | Zip Code) 27983 |
| - p # # # # | ł | 20a. Method of Disposition | | | Place of Disposit | ion (Name | | | Dai | | 20c. Location - C | | |
| Baltimore, permit Pages I an Department of He Important: If ite | | XBuria 2 Cremation 3 Removal from State crematory or other place) Domation 5 Other Specify HILLCREST CEMETERY 11-22-2006 WINDSOR, | | | | | | | | | | | NC |
| Baltin permit P Departme Importan injury or | ŀ | | Dovation 5 John Specify , HILLCREST CEMETERY 11-22-2006 WINDSOR, NC Signature of Funeral Service Licensee JONATHAN D. HIBNER Name and Address of Facility GILLIAM FUNERAL HOME | | | | | | | | | | |
| min Pe w | j | fauth | U. Afc | 13_ | . 70 | 06 GH | ENT | ST. | WINDS | OR, NO | ORTH CAR | OLI | NA 27983 |
| / Physician /Medical | | 23a Part I Enter the disease, or calure. List only one cause | complications that cause on each line. | d the death | . Do not enter the | mode of c | iying, su | uch as card | diac or resp | piratory arres | t, shock, or hear | t | Approximate Interval Between Onset and |
| Examiner | | Immediate Cause (Final disease or condition resulting in death) | a. Atherosclerotic | | | ise | | | | | | | Death |
| | | Sequentially list conditions, | Due to (or as a cons | sequence o | r): | | | | | | | | |
| | iner | if any, leading to immediate cause. Enter Underlying Cause | Due to (or as a con- | sequence o | f): | | | | | | | | |
| | Examiner | (Disease or injury that initiated events resulting in death) Last | Due to (or as a con: | sequence o | f): | | - | | | | | | |
| executed an and all - transit | | | d | | | | | | | | | | |
| be of icie | edical | UNPENDED | AMENDED | | | - | | | | | | _ | |
| Box 6876C ne death certificate r the attending phys ned for use as the b | ⋝ | IF FEMALE: 23b Was decedent pregnant in the | e 23c. If yes, outco | ome of preg | | al death | 3 | Ectopic p | regnancy | | 23d. Date of do Month | elivery Da | ay Year |
| Box 6 e death cert the attendit ed for use a | icia | past 12 months? | | at time of de | neth | er (Specify | 1) | | | | | | |
| Bo le deat | hys | | nown 9 Unknown | | | | | | | | | | |
| ision of Vital Records, P.O. Box Attending Physician: The law requires that the death r death. ector: After this certificate has been signed by the atte by the funeral director, page 2 should be detached for u. | | Part II. Other significant condition Diabetes mellitus | ons contributing to dea | ath but not r | esulting in the un | derlying ca | ause giv | en in Part | 1. | | | _ | ne cause of death? |
| ords, ** require s been sig | Completed by | | | | | | | | — ¦ | 24a Was an | 24b. We | ere auto | ppsy findings available |
| ital Recorician: The law rector, page 2 sh | ם | | | | | | | | | autopsy perform | ed? de | ath? | mpletion of cause of |
| Re: The | | 25. Was case referred to medical | | | | 26 | Diago | f Dooth /C | heck only | 1 Yes 2 | No 1 | Yes | 2 No |
| Vital ysician: his certifi director, | Be | examiner? | Describely and | tient 2 | ER/Outpatient | | 10 | thor: | Nursing Ho | | esidence 6 | Other | Scene |
| 1 of Vi ding Physi After this funeral dir | 7 | 1 Yes 2 No 27. Manner of Death | 28a Date of In | njury | 28b. Time of Inj | | | at Work? | | | w injury occurred | | |
| Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been siled in by the funeral director, page 2 should the | Certification: | 1 Natural 5 Pend | | r,Year) | | | 1 Ye | s 2 N | lo | | | | |
| IVISION Or Attent after death Director: | fica | | tigation 28e. Place of | Injury - At h | ome, farm, street | , factory, o | ffice bui | ilding, etc. | 28f. | | | or Rura | al Route Number, City |
| Divis | erti | | mined (Specify) | | | | | | | or Town, Sta | ite) | | |
| DIVI To the Hospital or within 24 hours afte To the Funeral Dir | | | nysician: To the best of miner:On the basis of ex | | | | | | | | | | |
| To th within To th | Medical | 29b. Signature and title of certifier | and manner stated | d, | | | icense i | | .,00 01 116 | | 29d Date signed | | |
| | - | | | KUD | | | D.C.M | | | | November 1 | | |
| | | | C. C.C. | | 230) | ` | | | | | | ., | - |
| 5 | | 30. Name and address of person Tasha Greenberg MD. | | | | enn Str | eet, B | altimore | e, MD 21 | 201 | | | |
| | ate | 31. Date filed (Month, Day, Year) | | rar's Signati | ure | | -, - | | | - | | | |
| - 3 | 25.13.7 | | 5 | | is for | 15 P | | | | | | | |

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

| | | | State of Maryland / Department of H | | Hygiene 115 | 37603 |
|------------|--|------------------------|--|--|---|--|
| | | | 1 - State Registrar Certificate of L 1. Decedent's Name (First, Middle, Last) | Death 2. Date of | Reg. No. | 3. Time of Death |
| | Physicia /Medic | | Jean Charlotte Stone | Nov | . as aco | 6 7:06pM |
| | Examin | | what he Advants to Harrison Tong | Location of Death | 4c. County of Dear | |
| 15 | Funeral | | 5. Social Security Number 1 | If Under 24 Hrs. 8. Date of (Month) | Montgo Birth Day, Year) 3-1938 S. | hplace (State or Foreign ountry) |
| | Director | | Usual Residence of Decedent | 15-5 | 3-1938 5. | Carolina |
| | filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or iteme 23a or 28a-f show int, ira Medical Examinat must be nutilied at | ror | 10a. State 10b. County 10c. City, Town or Location Silver Spring | | | 10d. Inside City Limits 1 XYes 2 No |
| | or 28a- | Funeral Director | 10e. Street and Number | 010 | 10g. Citizen of What Co | ountry? |
| | ne 23a | erail | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hi | 710 ispanic Origin? (Specify Yes o | No- 14. Race - Ame | |
| 36 | or ite | by Fur | Armed Forces? 1 Never Married 2 Married 1 Yes, Specify Cuba 1 Yes, 2 No 1 Yes, Give 1 Yes, Sive 1 Yes 2 No | n, Mexican, Puerto Rican, etc. Specify: |) Black, Whit | e, etc. |
| 215-0036 | 72 hour natural | | 15 Decedent's Education 16a Decedent's Usual Occupa | ation during most of working | 16b. Kind of Business | findustry |
| 2121 | within i ene. then "r | Completed | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done of life. DO NOT use regred |) | NA | |
| nd 2 | be filed ital Hygi id other event, I | Be | 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Mic | | hman |
| Maryland | should ind Men imarke | 은 | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street a | and Number or Rural Route Nu | | Jhman Zip Code) |
| | and 2 lealth a m 27 is | | Chuck Pritchard, son 5205 Gum | fork Dr. G | | e. 23061 |
| nore | Pages 1 nent of H int: If ite iry or ot | | 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | D 1 1/22/06 | 20c. Location - City or Williamsb | , |
| Baltimore, | permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mantal Hygiens. Department of Health and Mantal Hygiens integrant: If Item 27 is marked other than "natural", or iteme 23a or 28a-f show amy injury or other traumatic event, Ira Madical Examinational an approx. | | 21. Signature of Funeral Service Licensee 22. Name and Address | ss of Facility | | |
| 13.2 | 405 = a | | 23a, Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dyin | eral Home 7345 g, such as cardiac or respirato | | Approximate |
| | Physician | | shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition | | | Interval Between Onset and Death |
| | /Medical Examiner | | Due to (or as a consequence of): | of Attaba | 10 | |
| | pe is | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | and the second | 0 . | |
| ń | ate be executed sysician and he burial-transit | Examiner | that initiated events resulting in death) Last C. Due to (or as a consequence of): | my ousues | , , , , , , , , , , , , , , , , , , , | |
| 68760, | cate be physicia the bur | dicai | (a Hyperlenseon | | | |
| Вох 6 | h certifi ending use as | ın/Me | IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy | | 23d. Date of de | |
| P.O. B | The law requires that the death certificate attending physis as been signed by the attending physioage 2 should be detached for use as their | Physician/Med | in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 9 □ Unknown | | Month | Day Year |
| | es that I gned by be deta | by Ph | Part II. Other significant conditions contributing to death but not resulting in the underlying cause give | | Did tobacco use contribute to | |
| Records, | requ been shoul | eted | | | | obably 4 Unknown utopsy findings available |
| Re | The lay ate has page 2 | Completed | | | utopsy prior to death? | completion of cause of |
| Vital | Physician: this certific ral director, | Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | 26. Place of Death (Check o | | -4. |
| o | ng Phy fter this ineral d | on: To | 27. Manner of Death 1 Sanhatural 5 Pending 28a. Cate of Injury (Month, Day Year) 28b. Time of Injury World World Injury Wo | y at 28d. Descri | Residence 6 Other (Spe | City) |
| Division | Attending r death. ector: After by the fune | ficati | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office | | on (Street and Number or R | ural Route Number, |
| Ο̈́ | itel or / irs after ral Dire | Certi | 4 ☐ Homicide determined building, etc. (Specify) | City of | Town, State) | |
| | To the Hospitel or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Medical Certification: | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the tin (Check only one) 1 Medical Examiner: On the basis of examination and/or investigation, in my or and manner stated. | ne, date and place, and due to pinion, death occurred at the ti | the cause(s) and manner as me, date and place, and due | s stated. e to the cause(s) |
| | To th within To th comp | Me | 29b. Signature and title of certifier 29c. License | number | 29d. Date signed (Mont | h, Day, Year) |
| | 177 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | 2834. | 11/25 | 2001 |
| | 10 | | DR. PADMA CHIRUMAMILLA 7600 31. Date (iled (Month, Day, Year) 3. Abgistrar's Signature | CARROLLAVE. | TAKOMA PA | 20912 ORK Md |
| | Sta Regist | | NOV 2 8 2006 | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Garv Lee Schultz 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 **X**M 2 □ F 396-40-0121 63 March 29,1943 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel 1 ☐ Yes 2 ☑ No Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8387 Piping Rock Court 21108 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Government Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold Rudolph Schultz Bernice Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Yoon Hie Schultz/Wife 8387 Piping Rock Court Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov. 30. 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cem. 2006 Crownsville, MD 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature 6 Runeral Sprvice Licensee 1101411 1 Second Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ROBABLE ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∏ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Ves 2 No 2 ★ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) (DEBAJIT ROY D0060103 11.25.2006 MD, FACC)

To the Hospital or Atter within 24 hours after des To the Funeral Directo completely filled in by the State Registrar

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notifled at

item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be r

if Health and Mental Hygiene.

Physician

/Medical

Examiner

attending physician and for use as the burial-tran

ed by the a detached f

After

...al or Ah.
ours after deah.
al Director: Ah.
in by the fur-

be exect

Division or Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

þ

Completed

Be

٩

Certification:

Medical

Funeral Director

þ

Completed

Be

31. Date filed (Month, Day, Year)

NOV 2 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DEBAJIT ROY 7845 OAKWOOD ROAD, GLEN BURNIE MD 21061 32. Registrar's Signature

marks 3

| | | | For Amend #5 I | State of Ma | aryland / | /Depa 9706 | rtment | of Hea | ilth and | d Mental | Hygien | 2006 | 37605 |
|---------------------|--|---------------------|--|--|---------------------------------|-----------------------|---------------------------|--|---|--------------------------------------|------------------------------------|--|--|
| | ā. | | State Registrar 1. Decedent's Name (First, Middle, Las | | | Cer | lilicale | or De | alri | 2. Date of | | 10/2 0 0 0 | 3. Time of Death |
| | Physicia /Medic | al | Catherine I | ouise | Shaf | fer | 4h Cib. T | Town out or | nation of Dr | 11- | מריל ננוי | lc. County of Deatl | 6 2,0017 M |
| 7 | Examin | er | 4a. Facility Name (If not institution, give Baltimore Washi | ndown Mai | charl | Cant | 40. City, 1 | own, or Log | ly l | Burn | | Anne | Brundal |
| | Funeral Director | | 5. Social Saudity Number 6. S | | e (In yrs. last | / - | If Under 1 Months | | Under 24 H lours M | lin (Mont | of Birth n, Day, Yea 1.20, 1 | 9. Birtt Co. | nplace (State or Foreign untry) MD |
| | ō | | Usual Residence of Decedent | | 10c. City. To | oum or Lo | nation | | | 1,000 | | | 10d. Inside City Limits |
| | Aarylau Fahow | ō | MD Anne Aru | ınde 1 | , , , | n Bur | | | | | | | 1 Tyes 2 No |
| | r 28a- | rect | 10e. Street and Number | ilide I | OTC | II Dal | 10f. Zip (| Code | | | 10g. 0 | Citizen of What Co | untry? |
| | th with | al D | 426 Pine Terrace | | | | 2 | 1061 | | | U. | S.A. | |
| 920 | nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ariment of Health and Mental Hygiene. ortent: if item 27 is marked other then "natural", or items 23a or 28a-f show injury or other treumatic event. Ite Medical Examiner must be notified at lighty or other treumatic event. Ite Medical Examiner must be notified at 8.8. | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 🖫 Widowed 4 Divorced | 12. Was Decedent Armed Forces? 1 ☐ Yes 2 💥 If Yes, Give Year or Dates: | | | Vas Decede Yes, speci | 77 | inic Origin? Mexican, Pi Specify: | ' (Specify Yes o uerto Rican, etc | or No- .) | 14. Race - Ame Black, White Specify: W | |
| Maryland 21215-0036 | "natur | Completed | 15. Decedent's Ed (Specify only highest gra | fucation ide completed) | 1 | 6a. Deced | ent's Usual | l Occupation k done durir e retired) | n ng most of | working | 16b. | Kind of Business/ | ndustry |
| 121 | within ene. than " | dmc | Elementary/Secondary (0-12) | College (1-4or | 5+) | | ress | e retirea) | | | | Restaura | nt |
| d 2 | 2 should be filed within and Mental Hygiene. ia marked other than eumatic avant, the Mental avant, the Mental avant, the Mental avant, the Mental avant, the Mental avant, the Mental avant, the Mental avant, the Mental avant, the Mental avant, the Mental avant, the Mental avant, the Mental avant, the Mental avant, the Mental avant avan | Be C | 17. Father's Name (First, Middle, Last) | | | ware | ICOD | 18 | . Mother's | Name (First, M | iddle, Maid | | |
| <u>yar</u> | Menta Menta arked atic a | TO E | Joseph Sweenny | | | | | | | ldie Wa | | | |
| Mar | 12 shuh and 7 ia m | | 19a. Informant's Name/Relationship (Mrs. Geraldine Pa | | | | • | | | n Burni Burni | | y or Town, State, Z | lip Code) |
| | s 1 and 20 Health Item 27 | | 20a. Method of Disposition | | 20b. Place | | sition (Nam | | 1 - | Date | | Location - City or | Town, State |
| E | Pages nent of int: if i | | 1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | 1 | Have | n Mem | ı. Par | k | v. 29, 2006 | G1 | len Burni | e. MD |
| Baltimore, | permit. Page Department of Important: If any Injury or once. | | 21. Signature of June 14 Service Licer | nsee M | 0/41/ | 22 | . Name and | d Address o | f Facility S | ingleto W Glen | n Fur | neral Hom le, MD 21 | e, P.A. |
| | Physician | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition | plications that caused one cause on each li | d the death. I | Do not ente | er the mode | e of dying, s | uch as car | diac or respirat | ory arrest, | | Approximate Interval Between Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as | a consequen | ice of): | | | | | | | |
| | Examiner | e | Sequentially list conditions, | b. Due to for as | a consa uen | nce of): | | | | | | | |
| | uted d ansit | Examine | Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | 5-3.50 | | | | | | | | |
| 0, | be executed sicien and burial-transit | | resulting in death) Last | Due to (or as | a consequen | nce of): | | | | | | | |
| 68760 | # × 9 | edical | | d | | | | | | | | | |
| Box | The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as th | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown | 2 Fetal de | ath 3 | Ectopic pre Other (spe | | | | _ | 23d. Date of def Month | ivery Day Year |
| ds, P.0 | uires that the de signed by the a d be detached t | by | Part II. Other significant conditions of | contributing to death t | out not resulting | ng in the ur | ndarlying ca | ause given i | n Part I. | 23e. | -54 | | the cause of death? |
| Vital Records, | ie law requir has been si ge 2 should I | Completed | Hype | Lin | 5 7 | | ds | m | en) | ih 24a. | Was an autopsy performed | prior to | stopsy findings available completion of cause of |
| Ta I | | 0 | 25. Was case referred to medical | | | , | | 26 | 6. Place of | 1 ☐ 1 | - | No 1 ☐ Yes | 2 000 |
| Į. | Physicia this cert | To B | examiner? 1 ☐ Yes 2 ☐ No | Hospital: | ent 2□ER | VOutpatren | t 3 DO | Other | | | | 6 □Other (Spe | cify) |
| n of | ding Ph J. After th funeral | | 27. Manner of Death **Autural 5 Pending | 28a. Date of Inju (Month, Da | ury 28 ay Year) | 3b. Time of Injury | | 8c. Injury at Work? | | 28d. Des | ribe how in | fury occurred | |
| Division | Attender death | Certification: | 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined | e 28e. Place of In | jury - At home tc. (Specify) | e, farm, str | M eet, factory | | 2 □ No | 28f. Loca City | tion (Street or Town, St | and Number or Ru ate) | ural Route Number, |
| | Hospitel or 24 hours afte Funerel Dir etely filled in | edical C | | nysician: To the best miner: On the basis of and manner st | of examination | | | | | | | | |
| | To the within 2 To the comple | Me | 29b. Signature and title of certifier | 2 0 | | | 29c | . License ni | umber | ſ | 29d. l | Date signed (Mont | h, Day, Year) |
| | - | | 1-12- | 1 m |) | | | 148 | 00 | b | 11) | 24/21 | 006 |
| | 6 | | 30. Name and address of person who | empleted cause of | death (Item 20 | 3a) (Type, | Print) | rital | Dr | 1/6 | len | Burn | il, mD |
| | Sta Registi | | 31. Date filed (Month, Day, Year) | 32 Redist | rar's Signatur | e AM | read ! | / | | / | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2006 Nov. 26, 8:17P M Victor J. Shimkus, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 2931 A Walnut Ave. Owings Mills If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 923 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) XXM 2□F Illinois 83 346-18-5392 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes XX No Owings Mills Funeral Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21117 U.S.A. 2931 A Walnut Ave. 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2□ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married XX Married 1 ☐ Yes XXNo Specify. Specify: White Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Shimkus William Shimkus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores I. Shimkus / Wife 2931 A Walnut Ave. Owings Mills, MD 21117 Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cometer, crematory or other place)
Maryland Veterans
Cemetery XIXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/04/06 Owings Mills, MD 21. Signature 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 Examine

Physician /Medical **Examiner**

Funeral

Director

r 28a-f show notified at

filed within 72 hours after death with the Maryland Hygiene.

Hygiene "natural", or Items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or: any injury or other traumatic event, the Medical Examiner must be none.

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed burial-transit and attending physician I for use as the buria signed by the a certificate To the Hospital or Attending Physician:

Physician/Medical Ď Completed After this certific funeral director, Be P Certification:

within 24 hours after community to the Funeral Director: Aft

Division or Vital Records, P.O. Box 68760,

Medical

State Registrar

Km 206

31. Date filed (Month, Day, Year)

| 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death | |
|---|--|---|-----------------------|--|--|
| Immediate Cause (Final disease or condition | a colon cancer à metastasing | | | 2 month | |
| resulting in death) | Due to (or as a consequence of): | | | 3, 1,-0,-1, | |
| | | | | | |
| Sequentially list conditions, if any, leading to immediate | b | | | | |
| Cause (Disease or injury that initiated events | c | | | | |
| resulting in death) Last | Due to (or as a consequence of): | | | | |
| | ▲d | | | | |
| IF FEMALE: | One Marco cutoses of processors | | | | |
| 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome pf pregnancy □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) | | | 23d. Date of delivery Month Day Year | |
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to | | | | use contribute to the cause of death? | |
| | | | | Probably 4 ☐Unknown | |
| 24a. Was an autops: autops: prior to be performed? death? | | | | The off recast, 4 delikiowi | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of | |
| | | | | death? | |
| 25. Was case referred to medical 26. Place of Death (Check only one) | | | | 0 12:00 22:00 | |
| examiner? 1 ☐ Yes 2 ☑ No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | |
| 27. Manner of Death | 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred | | | | |
| 1 ☑Natural 5 ☐ Pending | (Month, Day Year) Injury | Work? | Work? 1 ☐ Yes 2 ☐ No | | |
| 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b | | | | | |
| 4 Homicide determined | | me, farm, street, factory, office 28f. Loc City | | ocation (Street and Number or Rural Route Number, ity or Town, State) | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number | 29d. D | ate signed (Month, Day, Year) | |
| mion- Door (Kicune) | | 031865 11/2 | | 11/28/06 | |
| (mion-vc | or / Moune) | 12 2 1 | | / | |

DHMH 17 Rev 1/2001

street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82

Entan

32. Registrar's Signature

Mian-Door

Baltimre

Kroune.

md

2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician Dav Vear Catherine Borowick Scelsi /Medical 2006 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 15288 Callaway Court Glenwood Howard If Under 1 Year Months Days 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 04/27/1921 Funeral Birthplace (State or Foreign Country) Months Hours 1 □ M 2 🗙 F 85 Director 218-07-1164 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Director MD Howard Glenwood 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 15288 Callaway Court U.S.A. Funeral 21738 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married I ☐ Yes 2 f Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3 ☑ Widowed 4 □ Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Clothing Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Leon Borowick Sarafina Catashowa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Ichniowski, Daughter 15288 Callaway Court, Glenwood, MD 21738 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Holy Trinity Cemetery 4 Donation 5 Dother (Specify) 11/30/2006 Elkridge, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5305 Harford Road, Baltimore, MD 21214 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mujo /Medical Due to (or a consequence of) Examiner Sequentially list conditions, france, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to (or se a nonesquence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Year 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 30 No Other: 1 ☐ Yes ို 1 Inpatient 2 □ ER/Outpatient 3□ DOA 4 Nursing Home 5 Nesidence 6 ☐ Other (Specify) 27. Manne f Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) 06

15

State Registrar

31. Date filed (Month, Day, Year)

Zus





30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Robert Vissing

State of Maryland / Department of Health and Mental Hygien 6 0 5 37608 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Nov 23, 2006 1910 Robert Sadler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel 191 Virginia Lane Apt H If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1XX M 2□ F 74 Yrs Director 214-30-5720 Oct 27, 1932 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic avant, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No XXX Director Glen Burnie Anne Arundel 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funerai 191 Virginia Lane USA Apt H 21061 Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2XXMarried 1 Yes Z No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Crane Operator Production 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Mary B. Lockhart Frederick G. Sadler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 191 Virginia Lane Apt H, Glen Burnie, ND 21061 Patricia Gary 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11-28-2006 Bayview Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatul of Funeral Service Licensee Name and Address of Facility Fink Funeral Home, P.A. K Gregory Cink M01148 426 Crain Hwy S., Glen Burnie, MD 23a. Part | Enter the disease, or con-shock or heart failure. List only Approximate Interval Between Onset and Death oplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest rook cause on each line. Immediate Cause (Final disease or candition resulting in death) **Physician** ances-Montus /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immodule cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ certificate has been signe rector, page 2 should be 182 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes ≥√ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending after death.

Director: Aft 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the e 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) November 27, 2006 or Glen Burnie MD. 21061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nan 305 Hospital 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 8 Registrar 2006

| | | • | For State Registrar | State of Mary | | artment of H tificate of L | | | ene g. No: 00 | 6 37609 |
|------------|---|----------------|---|---|----------------------------------|--|--|--|----------------------|--|
| ı | Physicia | an | 1. Decedent's Name (First, Middle, Last) | ~1 ! 1 | 77.2 | L - EE - | | 2. Date of Death Month | Day | 3. Time of Death |
| | /Medic Examin | al | 4a. Facility Name (If not institution, give stre | Shirley et and number) | Helen S | | Location of Death | Novembe | 4c. County of | |
| d. | LXamin | C1 | Greater Baltimore M | edical Ct | r. | Tows | | | | imore Co. |
| | Funeral Director | | 5. Social Security Number 6. Sex 1 ☐ M | 7. Age (li | n yrs. last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, NOV • 11 | | 9. Birthplace (State or Foreign Country) Maryland |
| | and | | Usual Residence of Decedent 10a. State 10b. County | 10 | Oc. City, Town or Lo | cation | | | | 10d. Inside City Limits |
| | Many a-feho | to | Maryland Baltim | ore | | | Dundalk | | | 1 ☐ Yes 2 🛣 No |
| | or 284 | Director | 10e. Street and Number | | | 10f. Zip Code | | 10 | g. Citizen of Wh | nat Country? |
| | e 23a | | 8056 Mid Haven R | | · 11.6 | 21222 | | | United | States - American Indian, |
| 30 | be filed within 72 hours after deeth with the Maryland ital Hyglene. Id other then "neturel", or Iteme 23a or 28e-f ehow event, the Medical Examiner must be inclified at | by Funeral | 11. Marital Status 12. 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced | Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | 1 | Was Decedent of Hi f Yes, specify Cuba I □ Yes 2☑ No | spanic Origin? (Sp n, Mexican, Puerto Specify: | Rican, etc.) | | , White, etc. |
| 215-0036 | 2 hou | | 15. Decedent's Educat | ion | 16a. Deced | lent's Usual Occupa | ation | 1 | 6b. Kind of Bus | White white white with the street with the str |
| Z | within 72 ene. then "ne! he Medic | Completed | (Specify only highest grade of Elementary/Secondary (0-12) | College (1-4or 5+) | life. L | kind of work done of OO NOT use retired | during most of work) | ing | | |
| N D | filed w Hygiei other tl | | 12 Years 17. Father's Name (First, Middle, Last) | | C1 | erk | 18. Mother's Nam | | | Security Admin. |
| yland | lid be hental rked o | To Be | Morris Blaustein | | | | | Rosa Be | | |
| Mary | 2 should and N le mail le mail | | 19a. Informant's Name/Relationship (Type, | | | ng Address (Street a | | | - | |
| ຄຸ ≥ | 1 and Health em 27 ther tr | | Daniel G. Steffe 20a. Method of Disposition | (Son) | 8056 20b. Place of Dispo | Mid Have | | | | nd 21222 Dity or Town, State |
| | ages ant of l nt: If its y or o | | 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify) | | cemetery, cren | natory or other place Service (| e) | | | , Maryland |
| Baitimore, | permit, Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Ie marked eny injury or other treumatic ev | | 21. Sharmure of Funeral Service Licensee | | 1 0 0cu | . Name and Addres da – Ruck E | s of Facility Funeral H | ome of D | undalk, | Inc. |
| u | | < | 23a. Part1. Enter the disease, or complica | tions that caused the | | 22 Wise A er the mode of dying | | | | 21222 Approximate Interval Between |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | Total | intesti | no at | ony | | | Onset and Death |
| | Examiner | | Convention list and divine | B Cat | onsequence of): | Bersa | 1 pne | moni | 7. | |
| . / | Sir & | lner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a co | onsequence of): | | | | | |
| V | cate be executed physicien and the burial-transit | Examiner | that initiated events c resulting in death) Last | Due to (or as a d | onsequence of): | · N- | | - | | |
| 8760, | ate be nysicie he bur | cal | d | | | | | | | |
| ٥ | | Med | IF FEMALE: | Maria automa afa | | | | | | |
| C. Box | ires that the death certifi signed by the ettending I be detached for use es | Physiclan/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown | Fetal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date Mont | of delivery th Day Year |
| λ, J | s that I | by Ph | Part II. Other significant conditions contri | buting to death but n | ot resulting in the u | nderlying cause give | en in Part I. | 23e. Did tob | acco use contrib | bute to the cause of death? |
| ğ | law requires that as been signed b 2 should be deta | | | | | | | 1 ☐ Ye | s 2□No 3 | 3 Probably 4 Gunknown |
| I Hecord | The ate h page | Completed | | | | | | 24a. Was ar autopsy perform 1 Yes 2 | pri ned2 de | /ere autopsy findings available for to completion of cause of eath? □ Yes 2 □ No |
| Vital | Physician: this certific ral director. | Be | 25. Was case referred to medical examiner? | pital: | | Othe | 00 | h (Check only one | | |
| ō | Phy r this rald | n: To | 1 165 2 JA40 | 28a. Date of Injury | 2 ER/Outpatien | I 30 DOX | 4 🗆 I vui siii g ric | me 5 Reside | | |
| <u> </u> | Attending F death, ctor: After y the funer | atlo | 1 Natural 5 Pending 2 Accident investigation | (Month, Day Ye | ear) Injury | | k? Yes 2 □ No | | | |
| Division | 2000 | Certification; | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury building, etc. (| · At home, farm, str Specify) | eet, factory, office | | 28f. Location (Str City or Town | | r or Rural Route Number, |
| | To the Hospitel of within 24 hours at To the Funerel Discompletely filled it | edical (| 29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine | ian: To the best of n r: On the basis of ex and manner stated | amination and/or in | n occurred at the tim vestigation, in my of | na date and plane pinion, death occur | and due to the ca red at the time, da | uss(s) and place, ar | nd due to the cause(s) |
| | To the h within 2: To the I | Me | 29b. Signature and title of certifier | | Λ | 29c. License | e number | 29 | d. Date signed | (Month, Day, Year) |
| ł | | | - Bankon | Many | | | राय७ उप | | 11/50/0 |)6 |
| | 5 | 1 | 30. Name and address of person who com | | n (Item 23a) (Type, ROAN | Print) | 4744 Rid | lge Road e, Maryl | and 01 | 226 |
| Į. | Sta | | 31. Date filed (Month, Day, Year) | 32 Registrar's | | | DOT CTHIOT | e, maryl | and 21 | 236 |
| | Registi | ar | NAV 9 9 2000 | 19.000 | H. Los | a se se | | | | |

DHMH 17 Rev 1/2001

| | - | For Stete Registrar | State of Marylan | • | irtment of F tificate of | | | ene . Ng2 () () (| 376L0 |
|--|-----------------|--|--|------------------|--|---|--|--------------------------------------|---|
| | | Decedent's Name (First, Middle, Last) | | | | | 2. Date of Death Month | Day Yea | 3. Time of Death |
| Physici | | Ma | rygeren Franc | ces Sch | noen | | | ber 19, 2006 | 1.00 m M |
| /Medic Examin | | 4a. Facility Name (If not institution, give s | | | | r Location of Death | | 4c. County of De | |
| Exami | | Ellicott Cit | ty Health & Rehab (| enter | | Elli | cott City | | Howard |
| Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. | | Il Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | | (ear) 9. E | Birthplace (State or Foreign Country) |
| Director | | 551-14-2190 | M 200 F | 35 Yrs. | Wichtins Days | Tiodis Will. | | | |
| D | | Usual Residence of Decedent | | | | | May 2, 19 | 921 | Illinois 10d. Inside City Limits |
| rylar how | | 10a. State 10b. County | 10c. Cit | ty, Town or Lo | cation | | | | 1 Tes 2 No |
| Ma Ma | 5 | Maryland Ho | ward | | E | Ilicott City | | | |
| th 10 m | Director | 10e. Street and Number | | | 10f. Zip Code | | 10g | . Citizen of What | Country? |
| 23a | | 2510 Kensington Garde | ns # 303 | | | 21043 | | | J.S.A. |
| filed within 72 hours after death with the Maryland Hygiene. Sther then "naturel", or Items 23s or 28s-f show ent, the Maclasi Evanti or must be notified at | Funeral | 11. Marital Status | Was Decedent Ever in U Armed Forces? | .S. 13. \ | Was Decedent of his Yes, specify Cub. | lispanic Origin? (S an, Mexican, Puert | pecify Yes or No- o Rican, etc.) | 14. Race - Ai Black, W | merican Indian, hite, etc. |
| or it | Ĭ, | 1 Never Married 2 Married | 1 ⊟ Yes 21 X No 1f Yes, Give | | 1□Yes 2⊠No | Specify: | | Specify: | \ A //= :4 ~ |
| iral, | d by | 3 Widowed 4 □ Divorced | Year or Dates: | | | | | | White |
| 72 h | Completed | 15. Decedent's Edu- (Specify only highest grade | | (Give | dent's Usual Occup kind of work done DO NOT use retire | during most of wor | rking | b. Kind of Busine | , |
| Pe Pe | d L | Elementary/Secondary (0-12) | College (1-4or 5+) | | | · . | 0 - 4 - 11 - | U | .S. Navy |
| led w | | 8 | | Secre | etary / vveap | | on Controller ne (First, Middle, Ma | iden Sumamel | |
| be fi | Be | 17. Father's Name (First, Middle, Last) | | | | TO. WOULD STAD | | ŕ | |
| should be and Mental marked o | ၉ | | Stanley | 100000 | | | Frankle Iral Route Number, C | Nelson Ger | |
| 2 sho and h | | 19a. Informant's Name/Relationship (Ty | pe, Print) | 1 | | | | | |
| s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-1 show other traumatic event, the Madical Exerciaer trains the collisistation. | | Mr. Stanley Schoen | Son | | 2510 Kensing sition (Name of | ton Gardens | # 303 Ellicot | t City, Maryla c. Location - City | |
| of H | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F | | | natory or other pla | ce) | 20 | oc. Location - City | or rown, state |
| Peg ment ant: ury | | 4 ☐ Donation 5 ☐ Other (Specify) | | Bay | view Cremat | WV. | 1/20/2006 | Balt | imore, MD |
| permit. Peges 'Department of H Important: If ite any injury or of | | 21. Signature of Funeral Service Scens | 96 | 22 | 2. Name and Addre | ss of Facility | | | |
| 20 = 2 3 | | 23a. Part1. Enter the disease, or compl | readout m | 01293 | Slack | Funeral Hom | ie, P.A. • Pike Filicott (| City MD 210 | 43 |
| | | 23a. Part1. Enter the disease, or compl. shock, or heart failure. List only or | ications that caused the dear ne cause on each line. | th. Do not ent | er the mode of dyi | ng, such as cardia | or respiratory arres | t, | |
| Physician | | Immediate Cause (Final disease or condition | CANCER | OF | BRA | IN | | | Monuto |
| /Medical | | resulting in death) | Due to (or as a consec | | (0)(1) | | | | 11/20/100 13 |
| Examiner | | A CONTRACTOR OF THE PROPERTY O | FAILURI | | TO TH | RIVE | | | morute |
| | Jer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consec | quence of): | | | | | month |
| betu: | Examiner | Cause (Disease or injury that initiated events | DENEN | TIA | | | | | month |
| an ar rial-t | Ex | resulting in death) Last | Due to (or as a consec | quence of): | | | | | |
| the death certificate be executed y the attending physician and ached for use as the buriat-transit | dicai | | j | | | | 131.00 | | |
| tifica ng ph as th | | ut court o | | | | | | 7 | |
| leath certific attending p | by Physician/Me | 23b. Was decedent pregnant | 23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta | | Ectopic pregnanc | v | | 23d. Date of | |
| deat e att | 100 | in the past 12 months? 1 ☐ Yes 2 ☐ No | 4 Pregnant at time of o | | Other (specify) | , | | Month | Day Year |
| that the de led by the a detached i | hys | 9 🗆 Unknown | 9LI ONKHOWII | V | | | _ | | |
| The law requires that ite has been signed b oege 2 should be deta | y P | Part II. Other significant conditions con | ntributing to death but not re- | sulting in the u | nderlying cause gi | ven in Part I. | 23e. Did toba | cco use contribute | e to the cause of death? |
| v require been sig should b | | | · · · · · · · · · · · · · · · · · · · | | | | 1 ☐ Yes | 2 □ No 3 □ | Probably 4 Unknow |
| aw requ is been 2 shoul | Completed | | | | | | 24a. Was an | 24b. Were | autopsy findings availab to completion of cause of |
| The lav ate has pege 2 | E | | | | | | autopsy performe | ed? death | to completion of cause o 1? ∕es 2 No |
| | Ö | 25. Was case referred to medical | | | | 26 Place of De | ath (Check only one) | | 2 110 |
| | 80 | | Hospital: 1 ☐ Inpatient 2 ☐ | ER/Outpatie | ot 313 DOA Ot | hor / | dome 5 ☐ Residen | | Specifyl |
| Phys r this ral di | - T | 27. Manner of Death | 28a. Date of Injury | 28b. Time o | | | 28d. Describe how | | ,pouny, |
| ding h. Afte fune | tor | t-⊠Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Year) | Injury | | rk?]Yes 2⊟No | | | |
| deal deal ctor: y the | fica | 3 Suicide 6 Could not be | 28e. Place of Injury - At I | nome, farm, st | reet, lactory, office | | | | r Rural Route Number, |
| after Dire | Certification: | 4 ☐ Homicide determined | building, etc. (Spec | | • | | City or Town, | State) | |
| To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | | | sician: To the best of my kn | | | | | | |
| ne Ho n 24 l ne Fu sletely | Medical | (Check only 2 Medical Exami | inar: On the basis of examin and manner stated. | ation and/or in | ivestigation, in my | opinion, death occ | 37% | | |
| To the To the To the Comp | Σ | 29b. Signature and title of certifier | | | | se number | | d. Date signed (M | |
| | | She | pre MD | | 1000 | 53150 | N | OV 2 | 000 000 |
| 1 | | 30. Name and address of perso oc Shawnma 31. Date filed (Month, Day, Year) | ompleted cause of death (Ite | m 23a) (Type, | Print) | | 5 | cute 110 | 0 40 |
| W | | Shalwama | la Supu | C 96 | 50 SC | ntiage | o Rd | Doumb | 15 21045 |
| St | ate | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | nature | AP a | | | | |
| Regis | | MOV 9 8 200 | c fee and B | . And | Charles . | | | | |

| | | 1- | For State Registrar | | State o | f Marylan | | rtment of I | | nd Mental | Hygien | 4000 | 37611 |
|--|------------------|---|---------------------------------------|---------------------------------------|--|--------------------------------|------------------------|--|-----------------|--|------------------------|---------------------------------|---|
| Physi | | | ecedent's Nan | ne (First, Middle, | _{Last)} John Jos | eph Ski | rvneck | i. Jr. | | 2. Date of Month | _ 0 | Pay Year | 3. Time of Death |
| /Med Exam | dica | | acility Name | | give street and nur | | | 4b. City, Town, o | or Location of | | | tc. County of De | |
| CXdII | mie | | | | - | MEDILL | AL CON | - | EN BU | _ | P | tring 1 | Afundel |
| Funera | al | | ocial Security | | 6. Sex, | 7. Age (In yrs. | | If Under 1 Year Months Days | | | f Birth 7, Day, Yea | | irthplace (State or Foreign Country) |
| Directo | or | | 089.30. | | 1 ⊠ M 2□F | 6 | 88 Yrs. | Worth's Day's | Tiours | | ber 9, 1 | | New York |
| and ** | | | Al Residence of State | of Decedent 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | | 10d. Inside City Limits |
| If I I I I I I I I I I I I I I I I I I | 1 | | | | Howard | | | | Elkridge | | | | 1 ☐ Yes 2 🛣 No |
| the 1 | 1 | 10e. | Street and No | umber | riowaiu | | | 10f. Zip Code | Likiluge | | 10g. C | Citizen of What (| Country? |
| h with | Finaral Director | | 6122 Ok | d Washingt | on Blvd. | | | | 210 | 75 | | ι | J.S.A. |
| deat | 1 | 11. N | Aarital Status | | T | edent Ever in U. | .S. 13. \ | Vas Decedent of H | Hispanic Origin | n? (Specify Yes of Puerto Rican, etc. | r No- | 14. Race - An Black, Wh | nerican Indian, |
| after of | 1 | 1 | | ried 2 Marrie | ed 1 Tes If Yes, Giv | 2 🔀 No | | ☐Yes 2⊠No | | | , | Specify: | White |
| Hours Hear | 2 | 3 | 3 ∐ Widowed | 4 🖾 Divorced | Year or D | ates: | 160 Door | lentin Havel Oncor | notion | | 1.0% | | |
| in 72 | je | | | | grade completed) | | (Give | lent's Usual Occup kind of work done DO NOT use retire | during most of | of working | 100. | Kind of Busines | S. Steel |
| filed withi Hygiene. other ther | Completed | | ementary/Sec | ondary (0-12) | College (1 | -4or 5+) | | Sale | es executi | ve | | 0. | o. oteel |
| other, | Be | 17. F | ather's Name | (First, Middle, L | ast) | | | | 18. Mother's | s Name (First, Mi | ddle, Maide | en Sumame) | |
| should be nd Mental marked o | F | <u> </u> | | John Jos | eph Skrynecl | ki, Sr. | | | | | Veroni | ca Melnik | |
| a de man | | 19a. | . Informant's N | Name/Relationsh | ip (Type, Print) | | | | | or Rural Route No | | | , Zip Code) |
| s 1 and 2 of Health Item 27 other tree | | - | . John Jo Method of Dis | oseph Skryi | necki, III | Son 20b. P | _ | 939 Brightw sition <i>(Name of</i> | ind Court | Ellicott City | | and 21043 Location - City of | or Town State |
| Pages nent of h int: If It | | | 1 Durial 2 | Cremation | 3 Removal from | State C | emetery, cren | natory or other pla | | | | | |
| | ۵ | 1 | | 5 ☐ Other (Sp uperal Service L | | All | County C | remation Se . Name and Addre | rvices. In | c. 11/25/200 | o l | Sykesvi | lle, Maryland |
| permit. Departr Importa eny inju | once | ١, | Hern | loller | Sed | MOUST | | Slack | Funeral H | Home, P.A. | O: | t. MD 040 | 40 |
| | | 23a | Fart1, Enter | the disease, or o | complications that only one cause on e | aused the deatl | h. Do not ent | | | nbia Pike El ardiac or respirato | | ty, MD 210 | Approximate Interval Between |
| Physicia | n | Imp | ediate Cause | (Final | INTR | | 20 36 | RAL B | (EED) | | | | Onset and Death |
| /Medica | | | alting in death | | _ a | (or as a conseq | | | 0, 0 | | | | |
| Examine | | Seq | uentially list c | onditions, | b. DIA | BETES | | BILITUS | | | | | |
| ed Islt | dia | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | |
| be executed icien and burial-transit | × × | Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | |
| Ite be exysicien | ja | | | | d | | | | | | | | |
| tificat ng phy as th | | | | · · · · · · · · · · · · · · · · · · · | | | | | | | | | |
| th cer tendir r use | A/ue | 23b. | EMALE: Was decede | | | come of pregna | | Ectopic pregnanc | v | | | 23d. Date of d | |
| the at | Dhyelclan/Med | | in the past 1: 1 Yes 2 9 Unknow | □ No | 4☐Pregn 9☐Unkn | ant at time of down | eath 5□ | Other (specify) _ | | | _ | Month | Day Year |
| hat th | | | | | ns contributing to d | eath but not resi | ulting in the ur | nderlying cause on | ven in Part I | 23e. [| Did tobacco | o use contribute | to the cause of death? |
| I NECOLUS, T.C. DOX 00/00, The law requires that the death certificate be executed ate has been signed by the attending physicien and paga 2 should be detached for use as the burial-transit | È | 5 | | | | | g | idony ing dadoo gi | | | 1 ☐ Yes | | Probably 4 Onknown |
| w requir been si should | Completed | | | | | | | | | 24a. \ | Was an | 24b Were | autopsy findings availabte |
| ding Physician: The lav funding Physician: The lav h. After this certificate has funerel director, paga 2 | 8 | | | | | | | | | a | autopsy performed? | prior to death? | completion of cause of |
| VICIAN: T Ician: T Sertificat ector, pa | 9 | 25.1 | | erred to medical | | ~ | | | 26. Place o | 1 ☐ Y | | 40 1016 | 55 Z NO |
| Physician: this certificated director, | E C |) | examiner? 1 🗌 Yes 2 🖔 | No | Hospital: 1 | npatient 2 | ER/Outpatien | 1 3□ DOA Ot | ner: 4 🗆 Nurs | ing Home 5 ☐ f | Residence | 6 ☐Other (Sp | ecify) |
| ing Phy Mer this | ġ | | Manner of Dea | ath 5 🗆 Pending | 28a. Date (Mon | of Injury th, Day Year) | 28b. Time of Injury | 28c. Inju Wo | ry at rk? | 28d. Desci | ribe how in | jury occurred | |
| Attending at death. ector: Afte by the fune | 1 | | 2 Accident 3 Suicide | investig 6 ☐ Could n | ation | of laive. At he | | | Yes 2 □ No | | on /Street | | D / D /- At b- |
| lor A affer Direction by | Cartification. | | 4 🗌 Homicide | determi | ned 289. Flace buildi | ng, etc. (Specif | y) | eet, factory, office | | City of | r Town, Sta | aria (valitaer or r | Ru <i>ral R</i> oute Number. |
| To the Hoepital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer | | | . Certifier | 1 Certifying | Physician: To the | best of my kno | wiedge, death | occurred at the ti | me, date and | place, and due to | the cause | (s) and manner | as stated. |
| n 24 l n 24 l he Fu | iedipa | | (Check only one) | 2 Medical E | xaminer: On the b | asis of examina ner stated. | tion and/or inv | estigation, in my | opinion, death | occurred at the ti | me, date a | and place, and de | ue to the cause(s) |
| To t Com | 2 | | Signature and | d title of certifier | | .04 | Co | 29c. Licens | se number | G | 29d. C | Date signed (Mo | nth, Day, Year) |
| | | | Mar | X Ce | 1- | | | ٠٠ | 7217 | ٦ | 8404 | rembe | x 23 2006 |
| 10 | | 30.1 | Vame and do | tress of person v | no completed caus | e of death (Item | 1 23a) (Type- | Print) | ar. | M BUN | 81140 | mi | 232006 |
| | State | 31. | Date filed (Mo | onth, Day Year) | €32. F | egistrar's Signa | iture | M. B | 7 | | | | |
| Regi | | | NO | JA 285 | 006 | 121 15 | A DESA | 94 | الموييد" | | | | |

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day 2006 NOV NOV **Physician** 22 4:40 P M JEAN SCULLION /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY BETHESDA NATIONAL NAVAL MEDICAL CENTER 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months Min 1 ☐ M 2 👿 F 058-20-2531 Vrs Northern Ireland 99 1907 26, Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 28a-f ehow other traumatic event, the Madical Examiner must be notified at 1 ▼Yes 2 No Rockville Directo Maryland | Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō death with 614 Muriel Street 20852 United States or iteme 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after I □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: þ White 3 ₩ Widowed 4 Divorced "natural" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental I ant: If Item 27 is marked or Joseph Nevin Sarah Nesbitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 765 Chambers Road, York, Pennsylvania 17402 William Scullion, Jr. /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1X Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any injury or once. injury or 4 □ Donation 5 □ Other (Specify) Arlington National Cemetery 21, 2006 Arlington, Virginia 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service-Licensee Letta Sumis M01305 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the 25 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day į in the past 12 months?
1 Yes 2 No 4☐ Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by P B 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed 2 🗆 No 2 💢 No 1 Yes Division of Vital funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🙀 No 1 V Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: the 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 06 D52862 Dourance 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600 MC USN KEVIN A. DORRANCE LCDR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 8 2006 Registrar

| | | · | 1 - For State Registrar | State of Marylan | | artment of F | | | giene (| 6 37613 |
|----------------------------|--|---------------|---|--|------------------|--|------------------|--|--------------------|---|
| | Physici | an | Decedent's Name (First, Middle, Last | | | | | 2. Date of De Month | ath Day | 3. Time of Death |
| | /Medic | | | cheidt | | | | u_ | | 2006 0640 M |
| | Examin | ıer | 4a. Facility Name (If not institution, give | | | 4b. City, Town, o. | | | 4c. County | |
| | | | | Mospitel | land frieds days | If Under 1 Year | If Under 24 | | | gomery |
| | Funeral | | 5. Social Security Number 6. Se 148–22–3917 | x 7. Age (In yrs. I | Yrs. | Months Days | | Ain. (Month, Pa | iy, Year) | 9. Birthplace (State or Foreign Country) New Jersey |
| | Director | | Usual Residence of Decedent | , , , | 9 | | | 0710 | 9130 | New Jersey |
| /land | Mo to | | 10a. State 10b. County | 10c. City | , Town or Lo | cation | | | | 10d. Inside City Limits |
| Man | - 9 | ţo | Maryland Montgome | ery | Bethes | da | | | | 1 ☐ Yes 2X No |
| h the | 128 | Directo | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of W | /hat Country? |
| death with the Maryland | 238 0 | | 9827 Singleton Dr | ive | | 20817 | | | United | l States |
| deal | S L | Funerai | 11. Marital Status | 12. Was Decedent Ever in U. Armed Forces? | S. 13. | Was Decedent of H | ispanic Origin | ? (Specify Yes or No uerto Rican, etc.) | - 14. Race | e - American Indian, k, White, etc. |
| ğ g | 声름 | | 1 ☐ Never Married 2 ☐ Married | 1 XiYes 2 ⊟No | 1 | 1 ☐ Yes 2Ñ No | Specify: | 001101110011, 010., | Specify: | |
| 5-UU36 72 hours af | Lead Engl | d by | 3X Widowed 4 □ Divorced | If Yes, Give Year or Dates: 1948 – | 52 | | | | | |
| 2 2 | in a | Completed | 15. Decedent's Edu (Specify only highest grad | | (Give | dent's Usual Occup kind of work done | during most of | working | 16b. Kind of Bu | siness/Industry |
| within | than the | 를 | Elementary/Secondary (0-12) | College (1-4or 5+) 4 | | ncial Ana | | | I.B.M | ſ |
| E N | al Hygie other I | e Co | 17. Father's Name (First, Middle, Last) | 4 | Filla | IICIAI AII | | Name (First, Middle | | |
| and and a | notal l | 100 | Leon H. Scheidt | | | | | ed Bennet | | ٥, |
| F jo | nark mark mati | 2 | 19a. Informant's Name/Relationship (T) | vne Print) | 19h Mailir | a Address (Street | | r Rural Route Numb | | State Zin Code |
| Ma d 2 st | than 17 Is trau | 1 1 | Leon P. Scheidt/S | | 1 | | | | | vania 16001 |
| ຄຸ ຊຶ | Heal tem 2 | - | 20a. Method of Disposition | | | sition (Name of natory or other place | | Date | | |
| more | in Fig | | 1 Burial 2 Cremation 3 F | nemoval mom State | | | NTone | . 28, 2006 | | City or Town, State lale |
| <u> </u> | Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, It's Medical Enaminer must be nutilised at anone. | | * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License | | | n Cemete: | - 3 | | New Jers | |
| Balti | Depa Impo any ii | | William A. Tru | | 173 Ro | bert A. Pu | nphrey F | uneral Home | , Bethesda | Chevy Chase, Inc. |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o | Δ | | | | | | Approximate |
| | :50% | | shock, or heart failure. List only o Immediate Cause (Final | | | , | 3 , | , | | Interval Between Onset and Death |
| | ysician Medical | | disease or condition resulting in death) | a. Shocl | | | | | | |
| | aminer | | | Due to (or as a consequ | | 4 T | | | | |
| | | Ē | Sequentially list conditions, | b. Myoc | uence of): | icel 1 | MTCEV | retron | | |
| / pe | _ usit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Rouse | 100 | -ules | | | | |
| be executed | al-tra | Xai | that initiated events resulting in death) Last | c. Due to (or as a consequ | - | Callera | | | | |
| ate be | ohysician and the burial-transit | cai | | d | | | | | | |
| | phys s the | 늉 | | u | | | | | | |
| . BOX by death certific | attending p I for use as | hysician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregna | | | | | 23d. Date | e of delivery |
| هِ مَ | d for | icia | in the past 12 months? 1 ☐ Yes 2 ☐ No | 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de | |]Ectopic pregnancy] Other (specify) | <u> </u> | | Mon | th Day Year |
| 9 | by the stached | hys | 9 Unknown | 9□ Unknown | | | | | | |
| ords, P.O | been signed t should be det | by P | Part II. Other significant conditions co | ntributing to death but not resu | ulting in the u | nderlying cause giv | en in Part I. | 23e. Did t | obacco use contri | ibute to the cause of death? |
| | n sig uld b | | | | | | | _ 10 | Yes 2 No | 3 ☐ Probably 4 ☐Unknown |
| ecord law requir | s peen s | ompieted | | | | | | 24a. Was | | Vere autopsy findings available |
| r e | page 2 | E | | | | | | | rmed?/ d | rior to completion of cause of eath? □ Yes 2□ No |
| | | C | 25. Was case referred to medical | | | | 26 Place of | 1 ☐ Yes Death (Check only of | | Yes 2 No |
| OT VITA Physicien: | | 0 8 | examiner? | Hospital: 1 Inpatient 2 🗆 | ER/Outpatier | t 3 DOA Oth | 00 | ng Home 5 Resi | | vs (Snecify) |
| 9 g | 윤글 | n: | 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of | | | | how injury occurre | |
| | ath. r: After e funera | atio | 1 Autural 5 Pending 2 Accident investigation | (Month, Day 16al) | Injury | | Yes 2 □ No | | | |
| UIVISION I or Attending | ecto ecto by th | ertification; | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At he building, etc. (Specify | me, farm, str | eet, factory, office | | 28f. Location (City or To | Street and Number | er or Rural Route Number, |
| ב ב | ours after deatl teral Director; filled in by the | Cert | 1 Tronners | building, etc. (Specin) | ′) | | | Oily or 70 | mi, State) | |
| ospit | within 24 hours after death. To the Funeral Director: After completely filled in by the funer | | 29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami | rsician: To the best of my kno | wiedge, death | occurred at the tin | ne, date and pi | lace, and due to the | cause(s) and mar | nner as stated. |
| he H | within 24 ho To the Fun completely | edicai | one) | iner: On the basis of examina and manner stated. | uon and/or in | vestigation, in my o | piniori, death o | ccurred at the time, | uate and place, a | nd due to the cause(s) |
| To ti | with To t | Σ | 29b. Signature and title of certifier | | | 29c. Licens | | | _ | (Month, Day, Year) |
| | N | | 1/1 | 1 | | DC | 177 | 2 | 11125 | sloc |
| 1 | (), (| | 30. Name and address of person who co | | | * | | | | |
| | ~ | | Tung Das, M | | | adze 1 | on su | rtx 2000 | Raclevi | |
| | Sta | | 31. Date filed (Month, Day, Year) | 2000 32. Reighstrar's Signa | ture | A STATE OF THE PARTY OF THE PAR | | | | 2081) |
| | Registi | rar | SEQ E NO | - | - 1 | | | | | |

11/24/06

Scheidt, Leon

| | | | _ FOI | epartment of Health and M Dertificate of Death | lental Hygie | 2000 07011 |
|----------------------------|--|-------------------|--|--|---|--|
| | | V | Decedent's Name (First, Middle, Last) | | 2. Date of Death Month | Day Year |
| · · | Physici /Medic | | Florence Virginia Staylor | | NOVEMBE | 2 24 2006 6:37 P.M |
| | Examin | er | 4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho | day) If Under 1 Year If Under 24 Hrs. | 8. Date of Birth | 9 Birthplace (State or Foreign |
| | Director | | 220-12-6315 1 M 2X)F 80 Yr | s. Months Days Hours Min. | (Month, Day, Ye 3 - 29 - 19 | 926 Maryland |
| | and | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of | or Location | | 10d. Inside City Limits |
| | Maryl -f sho | tor | MD Baltimore Co. Dundal | k | | 1 □ Yes 2, 1,No |
| | th the | Director | 10e. Street and Number | 10f. Zip Code | 10g. | Citizen of What Country? |
| | ath wi | rai | 7101 Martell Avenue | 21222 | | JSA |
| | ter de Itema | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 1 No | Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto) | ecify Yes or No- Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
| 936 | urs af | þ | 3 ☐ Widowed 4 ☐ Divorced Year or Dates: | 1 ☐ Yes 2 ☑ No Specify: | | Specify: White |
| 5 0 | within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show the Medical Exercine mant be inclined at | Completed | (Specify only highest grade completed) (0 | ecedent's Usual Occupation Give kind of work done during most of working | ng 16b | . Kind of Business/Industry |
| 2 | within ane. than | mpi | Elementary/Secondary (0-12) College (1-4or 5+) | ife. DO NOT use retired) Homemaker | T. | Iome |
| 2 2 | Hygie other ent, II | e Cc | 17. Father's Name (First, Middle, Last) | | | den Sumame) CONK) |
| ılan | uld be Mental rrked ric ev | To Be | George Weber | | | |
| Maryland 21215-0036 | 2 sho and ? le ma | 0 1 | | Mailing Address (Street and Number or Rura | | |
| e e | 1 and Health Bm 27 ther to | | | 1 Martell Avenue Disposition (Name of | - | Location - City or Town, State |
| ğ | ages ant of it: If it y or o | | 1 Burial 2 MCremation 3 DRemoval from State cemetery, | w Crematory Nov 2 | | • |
| altimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural; or items 23a or 28e-f show amy injury or other traumatic event, Ina Medical Examinatinatic burnelling all ance. | | 21. Signature of Funeral Service Licensee | | | Funeral Home, PA |
| m — | | | Tolar & Dodack, J. | 1201 Dundalk Aver | nue Balt | imore, MD 21222 |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. | t enter the mode of dying, such as cardiac o | or respiratory arrest, | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | pathy | | 1 year |
| | Examiner | | Due to (or as a consequence of) | estructive Pulmona | a. Die | esse 10 mes |
| | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury | | 7 1213 | |
| 1 | ecuted and transi | Examiner | Cause (Disease or injury that initiated events c | h. | | |
| 760, | The law requires that the daath certificate be executed tie has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit | | Due to (or as a consequence of) | u. | | |
| 687 | ificate g phys as the | Physician/Medical | d | | | |
| Вох | th cert endin | an/M | IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Felal death | 3 Ectopic pregnancy | | 23d. Date of delivery |
| о Ш | w requires that the daath certific been signed by the ettending p should be detached for use as: | sici | in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown 1 □ Yes 2 Mo 9 □ Unknown | 5 ☐ Other (specify) | | Month Day Year |
| P.O. | that the ed by detac | | Part II. Other significant conditions contributing to death but not resulting in ti | he underlying cause given in Part I. | 23e. Did tobac | co use contribute to the cause of death? |
| rds | quires n sign uld be | ed by | Dehydration | | 1 Yes | 2 No 3 Probably 4 Unknown |
| 000 | aw rec | Completed | Atrial Fibrillation | , | 24a. Was an autopsy | 24b. Were autopsy findings available prior to completion of cause of |
| Œ. | The law ate has page 2.4 | Com | | | performed | death? |
| Vita | vician: Th cartificate rector, pag | Be | 25. Was case referred to medical examiner? 1. The case of the second of | Other | Check only one | |
| ō | Attending Physician: or death. ector: After this carifice by the funeral director. It | 5 70 | 27. Manner of Death 28a. Date of Injury 28b. Tin | ne of 28c. Injury at | me 5 Residence 28d. Describe how i | e 6 Other (Specify) |
| <u>o</u> | ttending death. stor: Afte | atior | 1°∰Natural 5 □ Pending (Month, Day Year) Inju 2 □ Accident investigation | ury Work? M 1 ☐ Yes 2 ☐ No | | |
| Division of Vital Records, | l or Attending after death. Director: After in by the funer | Certification: | 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify) | n, street, factory, office | 28f. Location (Stree City or Town, S | t and Number or Rural Route Number, tate) |
| Ω | pitel o | | One Costifier (ST Costificion Discrimina To the heat of any knowledge | death and the time date and the second state of the second state o | | -(-)d -: |
| | To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this cartificate his completely filled in by the funeral director, page | edicai | 29a. Certifier 12 Certifying Physician: To the best of my knowledge, (Check only one Check only one Medical Examiner: On the basis of examination and/one and manner stated. | or investigation, in my opinion, death occurr | ed at the time, date | and place, and due to the cause(s) |
| | within To the | Me | 29b. Signature and I/Ie of certifier | 29c. License number | 29d. | Date signed (Month, Day, Year) |
| | ^ | | han Labello | H0055992 | | 11/27/06 |
| | 3 | | 30. Name and add ss of person who completed cause of death (Item 23a) (T | | 2015 | |
| 186 | Sta | ate | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | Holabird Ave 15 | BAlhmon | (MI) 21222 |
| | Regist | | MOV 2 8 2006 June 18 A | Societas | | |

DHMH 17 Rev 1/2001

ORIGINAL

| 3 | 7 | 6 | 5 |
|---|---|---|---|
| | _ | | |

| | 10000000 | | 1 - For State Registrar | State of M | aryland / De | epartment Certificate | | | d Mental Hy | ygiene () (| 06 | 37615 |
|--|--|-------------------|--|---|---------------------------------------|--|--------------------------------|--|--|--|--|--|
| | Physici /Medic | | Decedent's Name (First, Middle, L Mary Sindall | ast) | | | | | 2. Date of D Month NOVE | Day | Year 2006 | 3. Time of Death 2/45 M |
| | Examir Funeral | | 4a. Facility Name (If not institution, grade of the second | itan H | 05 pital | Jay) If Under | Pa/H | ocation of Do | re Irs. 8. Date of B | 4c. County | A 9 Birthola | ace (State or Foreign |
| × | Director | | Usual Residence of Decedent | 1 M 2 AF | 79 Yr | S. | Days | Hours N | March | 23 ^{Year} 1927 | | nown |
| | he Marylar 28a-f show | Director | MD | | Baltim | ore | | | | | | d. Inside City Limits 1X Yes 2 □ No |
| | eth with t | rai Dir | 10e. Street and Number 6116 Belair Road | | | 10f. Zip (| 06 | | | U.S.A. | | |
| 900 | 72 hours after deeth with the Maryland natural', or items 23a or 28a-1 show aftel Ezzani'ner musi be notitled at | d by Funerai | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates: | 7 | 13. Was Decede If Yes, speci | | panic Origin? Mexican, Pu Specify: | (Specify Yes or Nierto Rican, etc.) | Io- 14. Rad Blad | ce - America ck, White, et y: Wh | |
| 21215-0036 | within ene. then " | Completed | 15. Decedent's & (Specify only highest g Elementary/Secondary (0-12) Unknown | | 5+) | ecedent's Usual Give kind of work fe. DO NOT use | done dui | on ring most of | working | 16b. Kind of B | | istry |
| Maryland ? | ould be filed Mental Hygi arked other atic event, 1 | To Be C | 17. Father's Name (First, Middle, Lass Unknown | et) | , | | 1 | 8. Mother's I Unkno | Name (First, Middle WN | e, Maiden Suman | ne) | |
| | 12 sh h and 7 is m traum | | 19a. Informant's Name/Relationship Mariner Health o | | 611 | 6 Belai | r Roa | | Rural Route Number 1 | | | (lode) |
| Baltimore, | Page ment c ant: if ury or | | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 i 4 □ Donation 5 □ Other (Spec | rify) | cemetery, | isposition (Name crematory or other description of the contract of the contrac | ery | | 30 2006 | | ore, N | AD |
| Ball | permit. Pag Department important: eny injury c | | 21. Signature of Futieral Service Lice | 13 | | 6415 B | elai | r Road | , Baltim | ore, MD | 21206 | |
| | Pnysician /Medical Examiner | | 23a. Part1. Enter the disease, or conshock, or heart failure. List and Immediate Cause (Final disease or condition resulting in death) | a/OGO | terul a nsequence of) | Sep Sep | of dying, OSI LUV | such as card | frac or respiratory | arrest, | | Approximate Interval Between Onset and Death Day |
| 8760, | death certificate be executed e ettending physicien and by for use as the burial-transit | cal Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last | c. Sue to (or as | a consequence of a consequence of) | hoy | K | | | | 1 | Day |
| O. Box 6 | the death certifi y the ettending ched for use as | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 to No. 9 □ Unknown | 23c. If yes, outcome 1 Live birth 4 Pregnant a | 2 Fetal death | 3□Ectopic pre 5 □ Other (spe | | | | | te of delivery | y Day Year |
| rds, P | sign d be | ል | Part II. Other significant conditions | contributing to death | out not resulting in the | ne underlying ca | use given | in Part I. | | tobacco use cont | ribute to the | |
| of Vital Records, | The ate h page | Completed | | | | | | | 24a. Wa auto perf 1 □ Yes | opsy formed? | prior to comp death? | sy findings available pletion of cause of □ No |
| ion of Vit | Attending Physician: or death. ector: After this certifically the funeral director. | ation: To Be | 25. Was case referred to medical examiner? 1 Yes 2 No 27. Magner of Dealt | Hospital: 1 pati 28a. Date of Inju (Month, Da | ary 28b. Tim | atient 3 DOA | Other: c. Injury a Work? | 4 🗌 Nursin | g Home 5 Res | | | |
| Division | tal or Attences after death | Certification: | 3 Suicide 6 Could not determined | d 286. Place of in | jury - At home, farm tc. (Specify) | , street, factory, | office | | 28f. Location City or To | (Street and Numb own, State) | er or Rural F | Route Number, |
| | To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by | edicai | one) 2 Medicat Exe | Physician: To the best eminer: On the basis of and manner st | of examination and/o | feath occurred a or investigation, i | t the time, n my opin | date and pla lion, death or | ace, and due to the courred at the time | e cause(s) and ma , date and place, | anner as stat and due to th | ed. he cause(s) |
| | To the Vithin 2 To the complet | Σ | 29b. Signature amounts of certifier | mo | | 29c. | D 2 | 253 | 391 | 29d. Date signe | d (Month, De | 2006 |
| 3 | | | 30. Name and address of person who M·KI+AN | 5601-L | death (Item 23a) | rpe, Print) | 131 | sd, | Balti | more | NO. | 21239 |
| A. A. S. S. S. S. S. S. S. S. S. S. S. S. S. | Sta Registi | | 31. Date filed (Month, Day, Year) NOV 2 8 20 | 32: Regist | rar's Signature | aste) | | | | | | |

NOV 2 8 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year TRUDNG 30 NOVEMBURZZ 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN BAUIMORE MOJPITAL CIE NORTHWEST 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 M 2 □ F Days Hours Director 01/17/1922 China Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or flems 23s and any injury or other traumatic event. The Maryland once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 √Yes 2 No Director Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6989 Brookmill Road 21215 China. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗷 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No Completed by If Yes, Give Year or Dates: Specify: Specify: Asian 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chinese Pharmacist Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk. unk. ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Quang Truong 6989 Brookmill Road Baltimore, Maryland 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 12/02/2006 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road LAurel, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONLIESTIVE **Physician** disease or condition resulting in death) /Medical **Examiner** STA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 \(\text{No}\) 1□ Yes o the Hospital or Attending Physician: 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 **11**0 1 Hnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner as stated.

And manner stated. (Check only

State

29b. Signature and title of certifie

A. MAHTESHWARI 31. Date filed (Month, Day, Year)

NOV 28

Registrar DHMH 17 Rev 1/2001 Mb

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D53910

NORTHWEST HOSP CTR, RANDALLSTOWN, MD

29d. Date signed (Month, Day, Year)

NOV 23, 2006

Please Type or Print in Black Indelible Ink. Ensure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 17, 2006 2:36 P **Physician** Frances Evon Thomas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Havre de Grace If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Harford 105 Parkway Ave. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Sept. 4, 1 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2√2 F Virginia 1931 75 Director 227-36-5165 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County r Items 23e or 28e-f show treer-ust be natified at Directo Maryland | Harford Havre de Grace 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21078 105 Parkway Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status

1 ☐ Yes 2 XNo

Store Clerk

Brenda Carol Gray / Daughter 136 Wilson Street, Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Hilltop Service Corp. 11-27-06

Specify:

Lillie

McComas Funeral Home, P.A.

1 □ Yes 2 🛣 No If Yes, Give Year or Dates:

College (1-4or 5+)

1 Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

1 ☐ Burial 2 Cremation 3 ☐ Removal from State

3 ₩idowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Claud Cecil Cook

` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee

19a. Informant's Name/Relationship (Type, Print)

11

20a. Method of Disposition

10d. Inside City Limits

Black, White, etc.

White

Specify:

16b. Kind of Business/Industry

Grocery Store

20c. Location - City or Town, State

Month

Towson, Maryland

Approximate Interval Between Onset and Death

you;

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Wolfe

18. Mother's Name (First, Middle, Maiden Surname)

1317 Cokesbury Road, Abingdon, Maryland 21009

(unk)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Yes 2X No

Physician /Medical

þ

Completed

Be

2

or Attending Physicien: The law requires that the death certificate be executed as the burial-transit nding physician Division of Vital Records, After

Box 68760,

P.0.

Examiner Examine Physician/Medical þ Be Completed Certification: To s after dec. filled in by within 24 hours a To the Funerel D Medical

Immediate Cause (Final disease or condition resulting in death) COID Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic anemia 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🛣 No 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Transport of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Kluy 131295 11/20/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baul Al Charles St Suite 4702 NO 6701 Wendy Kloesz

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 8 2006

the

ORIGINAL

market

32. Registrar's Signature

| | | | 1 - For State Registrer | State | of Marylar | nd / Depa | artmen rtificat | t of H e of L | ealth a | and M | | Reg. No. | JU 6 | 3/6 | 18 |
|----------|--|-----------------|---|---|--|----------------------------------|---------------------------------------|------------------------------|---------------------------|------------------------|--------------------------------------|---|--|---|----------------------|
| | Physici | an | Decedent's Name (First, Middle | | | | | | | | 2. Date of D Month | Day | Year | 3. Time of | Death |
| | /Medic | | Barbara L. Thor | | | | 1 | | | | Novemb | | 2006 | 8:58 | A M |
| | Examin | er | 4a. Facility Name (If not institution | • | | | | | Location o | of Death | | | unty of Dea | | |
| _ | | | Montgomery Hosp 5. Social Security Number | 6. Sex | 7. Age (In yrs. | last hinthdayl | | kvil. | If Under | 24 Hrs. | 8 Date of F | | tgome | | or Foreign |
| | Funeral Director | | 167-42-9996 | 1□M 2\F | 56 | Yrs. | Months | Days | Hours | Min. | 8. Date of E (Month, 1) Dec. 1 | 6. 194 | | thplace (State of ountry) w Jerse | |
| | | | Usual Residence of Decedent | | 50_ | | 1 | | | | Dec. 1 | 0, 194 |) NE | w Jerse | У |
| | death with the Maryland ime 23a or 28a-f ehow r must be notified at | | 10a. State 10b. County | | 10c. C | ity, Town or Lo | cation | | | | | | | 10d. Inside Ci | • |
| | a-f | ctor | Maryland Montgo | mery | Bet | hesda | | | | | | | | 1 🗆 Yes | 2 X No |
| | or 28 | Olre | 10e. Street and Number | | | | 10f. Zip | Code | | | | 10g. Citizer | of What C | ountry? | |
| | 23a | rai | 6019 Kingsford | Court | | | | 817 | | | | 1 | | tes of A | nerica |
| | n 72 hours after death with the Marylan "naturel", or Iteme 23a or 28a-f show wilcal Examinar must be notified at | Funeral Directo | 11. Marital Status | 12. Was Dec Armed F | cedent Ever in l orces? 2 (2)No | J.S. 13. | Was Dece If Yes, spe | dent of Hi cify Cuba | ispanic Ori n, Mexicar | gin? (Spe n, Puerto | ecify Yes or N Rican, etc.) | No- 14. | Race - Am- Black, Whi | erican Indian, te, etc. | |
| S | s afte | by F | 1 ☐ Never Married 2 2 Marri 3 ☐ Widowed 4 ☐ Divorced | ed 1 Yes If Yes, G Year or | 2 (ANO live | | 1 🗆 Yes | 2[X] No | Specify: | | | Sp | ecify: | 1 | |
| 212-0030 | 72 hours after naturel', or Ite | | 15. Decedent | | Da(0 3. | 16a. Dece | dent's Usu | al Occupa | ation | | | 16b. Kind | of Business | hite | |
| | in 72 | Completed | (Specify only highes | t grade completed | | (Give | kind of wo DO NOT u | rk done d se retired | during mos | t of work | ing | | | , | |
| 7 7 | y within jiene. | mo | Elementary/Secondary (0-12) | 5+ | (1-4or 5+) | Teach | ner | | | | | Priv | ate S | choo1 | |
| <u> </u> | othe | Be C | 17. Father's Name (First, Middle, | Last) | | | | | 18. Mothe | r's Name | (First, Midd | le, Maiden Su | mame) | | |
| ā | Alenta Alenta rked rice | To E | Michael Matecki | | | | | | Agne | s F1 | eming | | | | |
| Maryland | and h | | 19a. Informant's Name/Relations | | | | | | | | | ber, City or To | | | |
| Σ | and 2 palith n 27 l | | Leonard H. Thom | pson, Sr | | | | | l Cou | | | , | | | |
| ore, | If item or othe | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation | 3 □Removal from | | Place of Dispo cemetery, crei | matory or o | ther plac | | | Date | | | Town, State | |
| Ē | Pag ment lant: | | 4 Donation 5 Other (S | pecify) | Gat | e of Hear | | | | - | | - | | ing, Mai | |
| Baltimor | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny injury or other traumatic event, Item 2002. | | 21. Signature of Funeral Service | Licy see | M008 | 96 75 | ort°A' 57 Wi | Puni scon | hrey sin A | Munera ve., | al Home/ Bethe | Bethesda esda, M | a-Chevy D 208 | Chase, I | nc. |
| | ilicate be executed by Medical Proposed and Jeans in the private items if the private in the pri | edical Examiner | 23a. Part1. Enter the disease, or shock, or feart failure. List timmediate Cause Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last | er Canc quence of): quence of): | | io di dyini | g, sucil as | cal diac (| л төэрласогу | all 631, | | Approximal Interval Bet Onsel and | ween | | |
| O. Box | death cert e attendin id for use | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown | 1 ☐ Live | utcome of pregr birth 2 Pet gnant at time of nown | al death 3 | ⊒Ectopic p ∃ Other (s _f | | | | | 230 | . Date of de Month | | Year |
| 1 | The law requires that the de ste has been signed by the a page 2 should be detached f | ۵ | Part II. Other significant condition | ens contributing to | death but not re | sulting in the u | nderlying o | ause give | an in Part I | | | tobacco use | | o the cause of c | |
| ecords, | w require been sli should t | etec | | | | | | | | | | | | | |
| T | | Completed | | | | | | | | | 24a. We aut per | opsy formad? | prior to death? 1 \(\sum \text{Ye:} | utopsy findings completion of c s 2 \(\square\) No | available ause of |
| VII | sician: Th certificate irector, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | | | Othe | | | Check on | | | Hospi | Ce |
| 5 | Phys this | 1. | 1 Yes 2 X No 27. Manner of Death | IL | | ER/Outpatier 28b. Time o | | JA | 4 140 | | | sidence 6 🖔 | | | tient |
| = | ding Phy h. After thi funeral | 를 다 | 1 Natural 5 Pendin 2 Accident investig | 9 | e of Injury onth, Day Year) | Injury | м | 28c. Injury Work 1 □ ` | k? Yes 2□ | | | | | | |
| Division | or Attending Physician: after death. Director: After this certificin by the funeral director, | Certification: | 3 Suicide 6 Could in determined | not be 28e. Place | ce of Injury - At I ding, etc. (Spec | nome, farm, str ify) | reet, factor | | | | | (Street and Nown, State) | lumber or R | ural Route Num | iber, |
| _ | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Medical Co | 29a. Certifier 1 Certifyin (Check only 2 Medical one) | g Physician: To the Examiner: On the and ma | best of my kn basis of examin | nowledge deal ation and/or in | h commed vestigation | at the time, | ne data an pinion, dea | id plane th occurr | and due to the | e nause(s) an e, date and pla | d manner a ace, and du | s stated e to the cause(s | ;) |
| | o the | Me | 29b. Signature and title of certifie | | | | 29 | c. License | number | | | 29d. Date s | igned (Mon | th, Day, Year) | |
| | ->-0 | | Cypethea M | Wille | amo I | DÖ | | HOO | 0580 | 32 | 2 | Nove | mber | 26, 200 | 6 |
| | 10 | | 30. Name and address of person | | | | | | | | | | | | 20855 |
| | 10 | | Cynthia M. Wil | liams, D. | | | | pice | , 600 |)1 Mu | ıncaste | er Mill | Rd., | Rockvi | .11e M |
| | Sta Registi | | 31. Date filed (Month, Pay, Year) | 8 2006 32. | Registrar's Sign | | back | P | | | | | | | |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

1_ For State

| | | | Registrar | | | C | erunc | ate of t | Jeam | | Reg. No. | | | | |
|---|--|------------------|--|--|---------------------------------|----------------------|--|--|----------------------------------|------------------------------------|-------------------------------------|--------------------------|--|--|--|
| · * • | أماميطا | | 1. Decedent's Name (First, Middle, I | | | | | | | 2. Date of I | | Year | 3. Time of Death | | |
| | hysici /Medi | | | Mildre | d Gree | r Tome | llini | - | | Novemb | per 16, | 2006 | 6:50 A | | |
| | Examir | | 4a. Facility Name (If not institution, g | | umber) | | 4b. C | | Location of De | eath | | ity of Death | | | |
| | | | Rockville Nursi | ng Home | | | | | kville | | | ntgom | nery | | |
| Fu | ıneral | | | .Sex 1 ☐ M 2 X 1 F | 7. Age (In yr: | | y) If Un Monti | der 1 Year | If Under 24 H | lin. 8. Date of E (Month, I | irth Day, Year) | 9. Birth | place (State or Foreign | | |
| Dit | rector | | 038-09-6150 | ILIM 2011 | 99 | Yrs. | | | | March | 28, 1907 | Rhc | odé Island | | |
| pu | 2 | | Usual Residence of Decedent 10a. State 10b. County | | 100.0 | City, Town or | Location | | | | | | 104 1-14- 05-11-5- | | |
| aryla | e ho | 7 | Toa. State | | 100.0 | ony, rowiroi | Location | | | | | | 10d. Inside City Limits | | |
| 9. | - 8 | octo | Maryland Montgo | mery | | | | tomac | | | | - | 1 ☐ Yes 2 🔀 No | | |
| di a | 0.2 | Dir | 10e. Street and Number | | | | 10f. | Zip Code | | | 10g. Citizen o | i What Cou | intry? | | |
| ath | 238 | a | 9925 Hall Roa | | | | | | 0854 | | United | Stat | es | | |
| ar de | tem L | Funeral Director | 11. Marital Status | Armed F | | U.S. 13 | If Yes, s | cedent of Hi pecify Cuba | spanic Origin? n, Mexican, Pu | (Specify Yes or Nerto Rican, etc.) | lo- 14. R: | ace - Amer ack, White | ican Indian, , etc. | | |
| 36 s atte | 0 | γF | 1 Never Married 2 Married | If Yes, G | 2 ሺ No live | | 1 🗆 Yes | 2 X No | Specify: | | Spec | ifv: T | 71 | | |
| d 21215-0036 filed within 72 hours atter death with the Maryland Hygiene. | ura E | Completed by | 3 ₩ Widowed 4 Divorced | Year or I | Dates: | 10- D | | | | | | W | hite | | |
| 21215-0036 sd within 72 hours atigiene. | | iete | 15. Decedent's (Specify only highest of | |) | /Gi/I | re kind of | sual Occupa work done of use retired | furina most of s | working | 16b. Kind of | Business/Ir | ndustry | | |
| withii | than E an | E G | Elementary/Secondary (0-12) | College | (1-4or 5+) | 1110 | | | | | | | | | |
| HAGE TO | of the | Ö | 17. Father's Name (First, Middle, La. | st) | | | HC | memak | | Name (First, Midde | | Home | 2 | | |
| or I be | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | Be | Samuel Greer | / | | | | | | roline M | | 1110) | | | |
| arylan should be nd Mental | nark | P | 19a. Informant's Name/Relationship | (Type Print) | | 10h Ma | ilina Addu | nea (Street s | | | | - Ct 7 | - 0-7-1 | | |
| Ma 12 s h an | 7 Is trau | | · | | | | | | | Rural Route Num | | | p Code) | | |
| e, N 1 and Health | Carol Greer Mitchell/Daughter 9925 Hall Road, Potomac, Maryla 20a. Method of Disposition 20b. Place of Disposition (Name of Date 2 | | | | | | | | | | | 20854 | own, State | | |
| 10a. State 10b. County 10c. City, Town or Location | | | | | | | | | | | North I | - | | | |
| Highland Memorial Park 2006 | | | | | | | | | | | | Igla | and | | |
| 3a ermii | any Ir | | 21. Signature of Funeral Service Lic | ensee | | I | 22. Name Rober | and Addres | s of Facility Pumphr | ey Funer | al Home | /Rock | ville, Inc | | |
| | _ 6 0 | | The same of the sa | | | 1198 | 300 W | est Moi | ntgomer | v Ave R | ockvill | e, MD | 20850-280 | | |
| | | | 23a. Part1. Enter the disease, or co shock, or heart failure. List on | mplications that ly one cause on | caused the de- each line. | ath. Do not e | nter the n | ode of dying | g, such as card | liac or respiratory | arrest, | | Approximate Interval Between Onset and Death | | |
| | sician | | Immediate Cause (Final disease or condition resulting in death) Yea | | | | | | | | | | | | |
| 753753 | edical miner | | Due to (or as a consequence of): | | | | | | | | | | | | |
| Exai | IIIIIei | | Sequentially list conditions, | b | | | | | | | | | | | |
| 7 0 | # | ne | if any leading to immediate cause. Enter Underlying Cause (Disease or injury | Oue to | or as a conse | quence of | | | | | | | | | |
| cute | trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c | | | | | | | | | | | |
| ္က်င္း | urial- | ŭ | resulting in deality cast | Due to | (or as a conse | quence of): | | | | | | | | | |
| lox 68760, | ending physician and r use as the burial-transit | an/Medicai | • | d | | | | | | | | - | | | |
| 6 | ing p | Mec | IF FEMALE: | | | | | | | | | | | | |
| | Itend or us | an/ | 23b. Was decedent pregnant in the past 12 months? | | utcome of pregr birth 2 ☐ Fe | nancy tal death 3 | □Ectopic | pregnancy | | | | ate of deliv | , | | |
| VISION Of VITAL RECORDS, P.O. B Attending Physicien: The law requires that the dea death. | signed by the atte t be detached for | Physicia | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 4□Preg 9□Unkr | nant at time of | death 5 | Other | (specify) | - | | IV | lonth | Day Year | | |
| at the | d by letach | Phy | | | | | | | | | | | | | |
| φ | gne bed | þ | Part II. Other significant conditions | contributing to c | death but not re | sulting in the | underlyin | g cause give | n in Part I. | 23e. Did | tobacco use cor | stribute to t | the cause of death? | | |
| Records, | been si | ted | | | | | | | | - 1 | Yes 2 No | 3 🗆 Prol | bably 4 X Unknown | | |
| <u>§</u> € | has be je 2 sh | Completed | | | | | | | | 24a. Wa | s an 24b | Were auto | opsy findings available ompletion of cause of | | |
| E 2 : | od late had be beginned in the late had be beginned in the late had been been been been been been been bee | | | | | | | | | p <i>e</i> r | ormed? 2 No | death? | | | |
| | this certificate has ral director, page 2 | Bec | 25. Was case referred to medical | | | | | | 26. Place of D | Death Check only | | | | | |
| ysic _ | is ce direc | To | examiner? 1 ☐ Yes 2 ➡ No | Hospital: 1 🗆 | Inpatient 2[|] ER/Outpati | ent 3 | DOA Othe | ır. | Home 5 ☐ Res | | her (Speci | fv) | | |
| 0 4 | ter th | Ë | 27. Manner of Death | 28a. Date | of Injury oth, Day Year) | 28b. Time Injury | | 28c. Injury Work | - 21 | | how injury occu | | -37 | | |
| at in in | F. A | atio | 1 XNatural 5 ☐ Pending 2 ☐ Accident investigate | | 701, Day 1841/ | прагу | М | | es 2 □No | | | | | | |
| DIVISION Of VITAL lor Attending Physician: atter death. | ecto by ⇔ | iffic | 3 ☐ Suicide 6 ☐ Could not determine | d 286. Flace | e of Injury - At I | home, farm, s | treet, fact | ory, office | | 28f. Location | (Street and Num | ber or Run | al Route Number. | | |
| tal or | ed in | Certification: | | build | g, 0.0. (3pec | ··· <i>y)</i> | | | | City of 16 | own, State) | | | | |
| psplt hour | uner ly tille | | 29a. Certifier 1 Certifying F | hysician: To th | e best of my kr | nowledge, de | th occurr | ed at the tim | e, date and pla | ice, and due to the | cause(s) and m | nanner as s | stated. | | |
| DIVISION TO the Hospital or Attentivition 24 hours after death | To the Funeral Director; After completely tilled in by the funer | Medical | (Check only 2 Medical Expone) | aminer: On the b | pasis of examin nner stated. | nation and/or | and/or investigation, in my opinion, death occurred at the time, date an | | | | | | o the cause(s) | | |
| Totl | To t | Σ | 29b. Signature and title of certifier | | 0 | | | 29c. License | | 29d. Date sign | 29d. Date signed (Month, Day, Year) | | | | |
| | | | > 人 | 1): | (h) | 1-1 | | D2 | 20148 | | Noveml | oer 2 | 1, 2006 | | |
| 1 | | | 30. Name and address of person who | o completed cau | se of death (Ite | em 23a) (Type | e, Print) | | | | | | | | |
| M | \ | | Steven Dolinsky, | | | | | e. Ga | ithersh | urg. Mar | vland 20 |)8 7 9 | | | |
| *** | Sta | te | 31. Date filed (Month, Day, Year) | 31. Date filed (Month, Day, Year) 32. Begistrar's Signature | | | | | | | | | | | |
| 1. Alt : | Reaistr | ar | NOV 2 8 | 2006 2 | Sellers . | de de | TAP 64 | Self- | | | | | | | |

DHMH 17 Rev 1/2001

Registrar

NOV 2 8 2006

| | | | Plea | | | Print in E Marylan | | | | | | _ | | _egible. | | |
|---|--|--|----------------------------------|--------------|--------------|-----------------------|------------------------|--|-------------------------|--------------------------|----------------------|--------------------------------|---------------------|----------------------------|-------------------|------------------------------|
| | | For State Registrar | | ` | Jidic oi | war ylari | | rtificat | | | IG IVI | | Reg. No. | 2000 | | 7620 |
| Physici | an | 1. Decedent's Name | | e, Last) | | | | | | | | 2. Date of De Month | ath Day | Year | 3. Tin | ne of Death |
| /Medic | al | MARY 4a. Facility Name (li | | a give str | L. | | THOMPS | 1 | Town, o | r Location of [| Death | 11 | 21 | 2006 County of Dea | | :30 P ^M |
| Examin | er | 122 ANJI | | | | 501) | | | | STATIO | | | 10. | BALTIM | | |
| Funeral | | 5. Social Security N | umber | 6. Sex | | 7. Age (In yrs. | last birthday, Yrs. | If Under Months | | If Under 24 | | 8. Date of Birt (Month, Da | y, Year) | 9. Bi | | ate or Foreign |
| Director | | 228-26-2 Usual Residence of | | | X | 82 | 115. | | | | | 06-17- | -1924 | - | VA | |
| trylanc thow | _ | 10a. State | 10b. County | D A T M | | 10c. Cit | y, Town or L | | | | | | | | | le City Limits Yes 2 ☐ No |
| the Ma 28a-f | Director | MD 10e. Street and Nur | | BALTI | MORE | | TU | RNER 1 | | CION | | | 10a Citi- | zen of What C | | res 2 INO |
| 3a or st be r | I Dir | 122 AN | | JSS C | OURT | | | 101. 210 | | 222 | | | rog. Oniz | US | | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy fujury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral | 11. Marital Status 1 □ Never Marri 3 ☒ Widowed | ied 2□ Man | 12 ried | | 2 TrNo | - 1 | Was Deced If Yes, spec 1 ☐ Yes | lent of H | | n? (Spec Puerto F | cify Yes or No Rican, etc.) | | I4. Race - Am Black, Wh | erican India | n, |
| 2 hou latura Icai Ex | ted | | 15. Deceden | it's Educa | tion | | | dent's Usua | | | of secondalism | . 1 | 16b. Kir | nd of Business | /Industry | |
| rithin 7 ne. han "r | Completed | Elementary/Seco | oify only highe ondary (0-12) | st grade t | College (1- | 4or 5+) | `life. | DO NOT us STIC 1 | e retire | | or workijn | g | но | SPITAL | | |
| filed w Hygie other th | S | 17. Father's Name | (First, Middle, | Last) | | | | | 22101 | | s Name | (First, Middle, | | | | |
| uld be Vental rked c | To Be | JAMES | EDMON | D | | | | | | SAR | AH | | | | | |
| 2 short and N is ma | | 19a. Informant's Name/Relationship (Type. Print) MICHAEL THOMPSON/SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S 734 N. AVONDALE ROAD, TURNER STATION | | | | | | | | | | | | | | |
| 1 and Health em 27 em 27 | | 20a. Method of Disposition 20b. Place of Disposition (Name of cametery crematory or other place) Date 20c. Location - City or other place) | | | | | | | | | | | | | | |
| Pages ent of nt: If it ry or o | | 20a. Method of Disposition State Substitute of Disposition State | | | | | | | | | | | | | | |
| permit. I Departm Importar any Inju | | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility TAMES A MODITON S CONG IT IT THE | | | | | | | | | | | | | | |
| e a m e e | | 1701 LAURENS ST. BALTIMORE, MD 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate | | | | | | | | | | | | | | |
| Physician /Medical | | 23a. Pp. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. The Count expiratory arrest, such as cardiac or respiratory | | | | | | | | | | | Interva | Between and Death | |
| Examiner | | Due to (or as a consequence of): | | | | | | | | | | | | | | |
| Po ti | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of): | | | | | | | | | | | | | | |
| be executed cian and ourial-transit | xam | Due to (or as a consequence of): Cause. Enter Underlying Gause (Disease on injury that initiated events resulting in death) Last Due to (or as a consequence of): C | | | | | | | | | | | | | | |
| e be e /sician e buris | | | | d. | | | | | | | | | | | | |
| rtificat ng phy s as the | Medi | IE EEMALE: | | | | | | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the but | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | | | | | | | | | | elivery Day | Year | | | |
| quires that en signed t | by | Part II. Other signif | ficant conditi | ons contr | buting to de | ath but not res | ulting in the u | inderlying c | ause giv | ven in Part I. | | | obacco us Yes 2[| se contribute t] No 3 | | of death? |
| he law re e has beo age 2 sho | Completed | | | | | | | | | | | | rmed? | prior to death? | completion | ngs available of cause of |
| ian: T | Be C | 25. Was case refer examiner? | red to medica | ıl | | | | | | 26. Place of | f Death | 1□ Yes (Check only o | 2 No ne) | 1 □ Ye | s 2□No | |
| Physic this ce al direc | 은 | 1 ☐ Yes 2 🔀 | | Ho | | · | ER/Outpatie | | | 4 ⊔ Nursi | | | | Other (Spi | ecify) | |
| iding in. Th. Tuner | tion: | 27. Manner of Deat 1 Natural 2 Accident | 5 Pendir investi | ng gation | 28a. Date of | n, Day Year) | Injury | M 2 | 8c. Injui Woi 1 □ | ryat rk? ∣Yes 2∐No | | 8d. Describe I | 10W Injury | occurred . | | |
| or Atter ter dea lirector n by the | 27. Manner of Death 1 St Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. 1 Ime of Injury M 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred | | | | | | | | | | ural Route | Number, | | | | |
| ipital cours af | | 29a. Certifier | 1 X Certifvii | na Physic | ian. To the | best of my kno | wledge dea | th occurred | at the ti | me date and | nlace a | nd due to the | cause(s) | and manner a | s stated | |
| ne Hos n 24 hc ne Fun bletely | Medical | (Check only one) | | | | sis of examina | | | | | | | | | | ise(s) |
| To the within To the Comp | Me | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, | | | | | | | | | | | th, Day, Yea | ar) | | |
| 1 | | May land A 30 64901 11-23-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | | | | | | | | | | | | | |
| 19 | | 30. Name and addr | ress of person | who com | pleted cause | of death (Iter | n 23a) (Type L | Print) | 0 | | | | | | | |
| Sta | | 31. Date filed (Mgh | ith, Day, Year, | 0.00 | 32. F | GUN (| ature | seed! | F | | | | | | | |
| Registr | ar | | NOV 2 | 8 20 | Ub Market | social. | 12. Ya | A DESCRIPTION OF THE PERSON OF | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Items 20b.c per fh 9861 II-28-06 vt. State of Maryland / Department of Health and Mental Hygierie 1 5

| | | • | For State Registrer | Otato or mary | | rtificate d | | Re | g. No. | 0,0= |
|---------------------|--|-----------------|--|---|--|-----------------------------------|--|---|--|---|
| | Physici | | Decedent's Name (First, Middle, Last) HILDA | LYO | INS | T | HORPE | 2. Date of Death | Day Year | 3. Time of Death |
| | /Medic Examin | | 4a. Facility Name (If not institution, give LEVINDALE HEBREW I | | | 4b. City, Tow BALTI | n, or Location of Deat | | 4c. County of Death | |
| | Funeral Director | V.G | | 7. Age (/ | n yrs. last birthday) 86 Yrs. | | ear If Under 24 Hrs. Hours Min. | | 9. Birth 920 | place (State or Foreign intry) MD |
| | Maryland | ctor | Usual Residence of Decedent 10a. State 10b. County MD BALTIMO | | DC. City, Town or LO BALTIMO | | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| | ath with the Marylan 23a or 28a-f ehow ust be mailled | ai Director | 10e. Street and Number 207-A OAK AVENUE | | | 10f. Zip Coo | ^{de} 208 | 10 | og. Citizen of What Cou | • |
| 036 | hours after death with the Maryland tural', or iteme 23a or 28a-f ehow at Examinar must be notified at | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: | : | Was Decedent If Yes, specify (| of Hispanic Origin? (S Cuban, Mexican, Puer No <i>Specify:</i> | pecify Yes or No- to Rican, etc.) | 14. Race - Ameri Black, White, Specify: | |
| 21215-0 | within 72 ene. than "nai | Completed | 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) | cation e completed) College (1-4or 5+) | (Give | DO NOT use re | one during most of wo | rking | 16b. Kind of Business/fr LAW FII | • |
| Maryland 21215-0036 | ld be filed ental Hyg ked othe ic event, | To Be C | 17. Father's Name (First, Middle, Last) HARRY 19a. Informant's Name/Relationship (T) | ing Print) | | LYONS | ISABEL | me (First, Middle, N | | BLUMBERG |
| _ | s 1 and 2 shou f Health and M item 27 Is mar other traumat | | TERRI ANGER / DAUG | HTER | 1216 | RUSTIC | AVENUE - | BALTIMORE | , MD 21237 | Own State |
| Baltimore, | 00 | | 20a. Method of Disposition 1 \(\overline{\Omega}\) Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) | Removal from State | ULANEY" VI | TELEYOUM - GARDEI | emorial 1 | 1-27-06 T | OCKEYSVILLI | E, MD |
| Bal | permit. Page Department Important: If any injury o | | 21. Signature of Funeral Servicer Licens 23a. Part 1 Inter the disease, or amplished, or heart failure. List only o | ications that caused the cause on each line. | e death. Do not en | 900 REI | STERSTOWN dying, such as cardia | ROAD - PI c or respiratory arre | | |
| | Physician /Medical Examiner | ner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a co | onsequence of): Sclesoft onsequence of): | Dem | Liovasce | ular D | isca se | |
| 68760, < | icate be executed physician and s the burial-transit | Medical Examine | Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a c | onsequence of): | | | | | |
| .O. Box 6 | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12-moeths? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of 1 Live birth 2 [4 Pregnant at times 9 Unknown | Fetal death 3 | □Ectopic pregn | | | 23d. Date of deliv Month | very Day Year |
| 0 | quires that in signed b uld be deta | by | Part II. Other significant conditions co | ntributing to death but r | not resulting in the t | underlying causi | e given in Part I. | | pacco use contribute to | |
| Il Records, | The ate h page | Completed | | | | | | 24a. Was ar autops perform 1 Yes 2 | y prior to co | opsy findings available ompletion of cause of |
| Vital | Physician: this certific ral director, | Be | 25. Was case referred to medical examiner? | Hospital: | | | | ath Check only one | | |
| ō | ding h. After fune | ation: To | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 1 Inpatient 28a. Date of Injury (Month, Day Y | 2 ER/Outpatie 28b. Time (Injury | of 28c. | Injury at Work? 1 Yes 2 No | | nce 6 Other (Speci w injury occurred | fy) |
| Division | 1 th 0 | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury building, etc. (| · At home, farm, si 'Specify) | treet, factory, of | fice | 28f. Location (St. City or Town | reet and Number or Rui n, State) | al Route Number, |
| | To the Hospital within 24 hours a To the Funerel Completely filled | edical (| | | camination and/or in | | | | sus a(s) and manner as a ate and place, and due | |
| 1 | To th withir To th comp | M | 29b. Signature and title of certifier | | - | | 23767 | _ | 9d. Date signed (Month) | - |

State Registrar

completed cause of death (Item 23a) (Type, Print)

2) memory 2434 W. Beheeder Ave, Balto, Fld 21215

32 pagistrar's Signature Debry Westhernesso 31. Date filed (Month, Day, Year) NOV 2 8 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37622 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 23 2006 **Physician** LOUIS TANKIN 10:20P M /Medical H 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RUXTON PIKESVILLE NURSING HOME PIKESVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 217-40-9826 08/01/1914 Director 92 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 75 RIVER OAKS CIRCLE 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Ves 2 NARMY 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 □ Yes 2 No If **N**es, Give Year or Dates: þ Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PHYSICIAN MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **BERTHA** HARRY **JACOB** TANKIN HABERER ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
75 RIVER OAKS CIRCLE - BALTIMORE, MD 21208 19a. Informant's Name/Relationship (Type. Print) RUTH TANKIN / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DHEB SHALOM 11/26/2006 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Thrombosis /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or cannot cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): sician a P.O. Box 68760, physi the b IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by Advanced Dement 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown CANCE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 2 10 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

20 Sta

State ³¹ Registrar

KOMO L. Babitt, M.D. 25 Main
31. Date filed (Month, Day, Year)

NOV 2 8 2006

Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karen R. Balrit, M.D



00058676

25 Main Street, Suite 200 Reisters town

November

21136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** November 6:30PM Robert T. Vogel 25,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore County If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1□M 2□F Months Days 76 Mar. 06, 1930 Baltimore, MD Director 213-26-9244 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Baltimore Co. Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4419 Field Green Road 21236 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: Orean 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2000 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Conflict ecedent's Usual Occupation Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygienn Important: If item 27 is marked other tha any Injury or other traumatic event, the <u>Nonce.</u> Sales Food Industry 12 n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Vogel Frances Rebbert ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine L.Vogel(wife) 4419 Field Green Rd. Baltimore, MD. 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St.Joseph Ch.Cem.Nov.30,2006 Fullerton,MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Euperal Service Li Evans Funeral Chapel&CremationServices 8800 Harford Rd. Parkville, MD. 21234 23a. Party Enlar use disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, which art fillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) **Physician** carcinona KOUS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Completed by Physician/Medical Examiner day, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed the burial-tran Due to (or as a consequence of): attending physician for use as the buris use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) led by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2□No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on director Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ≥ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To this funeral 28a Date of Injury 28b Time of 28d. Describe how injury occurred 27. Manner of Ceath 28c. Injury at Work? 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

P.0. Records, Division or Vital spital or Attending P nours after death. ineral Director: After t y filled in by the funera within 24 hours a To the Funeral I To the Hospital

Baltimore, Maryland 21215-0036

241

Registrar

29a Certifier

6601

and manner stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

s of person who completed cause of death (Item 23a) (Type, Print)

alles street/Balts

DHMH 17 Rev 1/2001

Villiams.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month - 20-2006 **Physician** MARION EMILY WILCOX 8:40P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPITAL CENTER WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Date of Birth (Month, Day, Year) 1-26-1932 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F 577-44-0986 74 Yrs WASHINGTON, DO Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or Items 23a or 28e-f ehow other traumatic event, the Medical Example must be notified at MD CARROLL 1 ☐ Yes 2 No Director SYKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6463 DANIEL CT. 21784 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: WHITE 3 ₩Widowed 4 Divorced "naturai", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/a SECRETARY PROPERTY MANAGEMENT permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe ery injury or other traumatic event, odgs. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) JESSE CLEVELAND HAIFLEIGH EMILY FRENCH McWILLIAMSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6463 DANIEL CT. SYKESVILLE, MD 21784 CAROLYN J. TAYLOR/LONG Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Dther (Specify) EVANS FUNERAL HOME 11-26-2006 FOREST HILL, MD 21. Signatus of Funeral Service Licenses 22 PEACEFUL FALTERNATIVES FUNERAL AND CREM. Let d-CENTER 2325 YORK RD. TIMONIUM, MD 21093 . Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastari Cancer **Physician** lyear /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. physician Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Dther (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Winknown 1 □ Yes 2 □ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed) 1 ☐ Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Dutpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After t 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 052035 2006 Nou 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminister MD 2/157 291 CHACKO Stoner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William Weisenmiller November 24, 2006 7:52 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral **™** M 2□ F Months Days 215-56-4213 60 Director September 10,1946 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits "natural", or items 23a or 28a-f shov idical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5444 Old Court Road 21133 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 █️No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced er than "natur, the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental R marked ပ Paul William Weisenmiller Mary Ellen Thompson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>s</u> Sherrill Owens (Sister) 3379 Highway 126, Blountville, TN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State rtant: If i 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory Inc. 11/28/06 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD. 21228 pernit.
Dep rtm
Importa
any Inju 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 21. Signature of Funeral Service Liour 8728 Liberty Road, Randallstown, Maryland 21133 Mc0333 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one sause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.O. signed by the a 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autop performe 2 b certificate 1☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) WSPICE 2 ER/Outpatient 3 DOA P 1 Inpatient funeral Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) . Charles St/Balto MD 6601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 8 Registrar

DHMH 17 Rev 1/2001

| | | For State | State of Marylan | | partment ertificate | | | lental Hy | | C 0 | 06 | 37627 | |
|--|--------------------------|---|---|--------------------|----------------------------------|-----------------------|---|--------------------------|-----------|------------------|--------------------------|--|--|
| | | Registrar 1. Decedent's Name (First, Middle, Last, |) | | Crimoato | | Douin | 2. Date of D | | | | 3. Time of Death | |
| Physicial /Medica | | Pamela C. 1 | Villiams | | | | | No Ven | | 26 | 2006 | 6:524 M | |
| Examine | | 4a. Facility Name (If not institution, give | | | | Town, or | Location of Death | | 4 | 4c. County | of Death | | |
| | | St. Agnes 5. Social Security Number 6. Se. | HOSPI (A) | la st hirthdi | B / | 1 Year | If Under 24 Hrs. | 8. Date of B | irth | | 9 Right | Nace (State or Foreign | |
| Funeral Director | | | M 2EF 50 | Yrs | Months | | Hours Min. | (Month, D | ay, Yea | (r) | Cour | place (State or Foreign htry) | |
| P > | | Usual Residence of Decedent | 10- 6 | | 1 | | | | 7 10 | | | | |
| shov | <u>ا</u> | 10a. State 10b. County | | y, Town or | | | | | | | , | 0d. Inside City Limits 1 X Yes 2 □ No | |
| the M | ect | 10e. Street and Number | 200 | 17im | 10f. Zip | Code | | | 10a (| Citizen of \ | What Cour | | |
| 53a or | 0 | 1011 Cameron | Rd | | 319 | | | | US | | | , | |
| aryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Manital Hygene. I marked other then "natural; or iteme 23e or 28e-f show umatic event; the Madical Exam in must be notified at | Funeral Director | 11. Marital Status | 12. Was Decedent Ever in U. Armed Forces? | .S. 1 | | | ispanic Origin? (Spe in, Mexican, Puerto | ecify Yes or N | | 14. Rac | ce - Americ | | |
| 36 safter | by Fu | 1 Never Married 2 Married | 1 ☐ Yes 2 🗷 No If Yes Give | | 1 □ Yes 2 | | Specify: | | | Specif | | oic. | |
| 5-003 | ed b | 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Edu | Year or Dates: | 16a De | cedent's Usua | I Occup | ation | | 16h | Kind of B | usiness/In | <u></u> | |
| Ind 21215-0 be filed within 72 ho tal Hyglene. d other then "natur event, the Medical | Completed | (Specify only highest grad Elementary/Secondary (0-12) | e completed) College (1-4or 5+) | (G life | ive kind of wor e. DO NOT us | k done d e retired | during most of worki | ing | 100. | Kille of D | u311103381111 | dustry | |
| 21. | E O | 12ty Geade | Conego (1-401 34) | Hor | nemat | Ler. | | | DE | mes | stic | | |
| be file | Be | 17. Father's Name (First, Middle, Last) | | | | | 18. Mother's Name | (First, Middle | e, Maide | en Suman | ne) | | |
| ryle hould d Mer marke | 2 | 19a. Informant's Name/Relationship (Tr | | 10h M | ailing Address | (Stroot | and Number or Rura | 1 ay lo | R Cit | . ar Taum | Ctata Zin | Codol | |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or eny injury or other treumatic event, the Madical Examples. | | Terrell R. Willia | | 1011 | C | 100 | 2.00 | | | | | (2006) | |
| other | | 20a. Method of Disposition | 20b. P | lace of Dis | sposition (Namerematory or ot | e of | | moze, | | | City or To | own, State | |
| imor Pages nent of I ant: if it | | t Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) | temoval from State | | | D. | -10 h. 1- | 2006 | Provi | rlalk | dan | am. | |
| Balt permit. Dapartr importe | Ì | 21. Signature of Funeral Service Licens | 99 | U | 22. Name and | Addres | ss of Facility | nepal s | SVC | | 11250 | 3,,,0 | |
| w gggga | _ | Youghn (| - Greene | | 5151 B | CHO | ss of Facility Second Fu Nutl | HE B | alt: | MORE | 7M7 | 21229 | |
| | | 23a. Part1. Enter the disease, or compleshock, or heart failure. List only or | ne cause on each line. | | | | g, such as cardiac o | or respiratory | arrest, | | | Approximate Interval Between Onset and Death | |
| Physician //Medical | | Immediate Cause (Final disease or condition resulting in death) | 1Srrast | | 4NC & | OK_ | | | | | L | INKnown | |
| Examiner | | | Due to (or as a consequence of): | | | | | | | | | | |
| 0 | Je | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conseq | uanca ot). | | | | | | | | | |
| 60, Control of the second of t | Examiner | Cause (Disease or injury that initiated events resulting in death) Last |). | | | | | | | | | | |
| 38760, icate be exe physicien at the burial-t | E E | resolung in death) cast | Due to (or as a consequent | uence of): | | | | | | | | | |
| phys cate | edicai | | d | | | | | | | | | | |
| BOX 6 Beath certification attending | Ž | IF FEMALE: 23b. Was decedent pregnant | 3c. If yes, outcome of pregna | | • T = · · · | | | | | 23d. Da | te of delive | nry | |
| death of attended for the set | Completed by Physician/M | in the past 12 months? 1 ☐ Yes 2 ☑ No | 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown | | 3 □Ectopic pre 5 □ Other (spe | | | | | Мо | onth | Day Year | |
| igned by the a be detached if | ב ה | 9 Unknown | | | | | | 1 | | | | | |
| ries th | 2 | Part II. Other significant conditions con PNEUMONIA. | ntributing to death but not res | ulting in the | e underlying ca | use give | en in Part I. | | | | ribute to th 3 ☐ Prob | ably 4 Minknown | |
| Cord Cord M requir | etec | 110000000000000000000000000000000000000 | | | _ | | | | | | | | |
| I Rec | Ĕ | | | | | | | 24a. Wa: auto perf | | 246. | prior to cor death? | psy findings available mpletion of cause of | |
| Wital Records, B. Ician: The law requires that the certificate has been signed by sector, page 2 should be detained. | 0 | 25. Was case referred to medical | | | | | 26. Place of Death | 1 Yes | 200 | | 1 🗆 Yes | 21XNo | |
| dis s | 0 | examiner? | lospital: 1 Inpatient 2 | ER/Outpat | tient 3 DO | Othe | | | | 6 □Oth | er (Specify | ·) | |
| Division of ion attending Phy effection. After this in by the funeral in by the funeral | | 27. Manner of Death Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time Injur | e of 28 | c. Injury | | 28d. Describe | | | | | |
| isio | cati | 2 Accident investigation 3 Suicide 6 Could not be | | | М | | Yes 2 □No | | (0) | | | | |
| Divi | Certification: | 4 Homicide determined | 28e. Place of Injury - At he building, etc. (Specify | me, rarm, | street, factory, | office | | City or To | (Street a | and Numb ite) | er or Rura | l Route Number, | |
| Hospitei | | 29a. Certifier 1 Certifying Phys | sician: To the best of my kno | wledge, de | eath occurred a | t the tim | ne, date and place, a | and due to the | e cause(| (s) and ma | inner as st | ated. | |
| Divisio To the Hospitei or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fi | edical | (Check only 2 Medical Exami | ner: On the basis of examina and manner stated. | tion and/or | investigation, | in my op | pinion, death occurr | ed at the time | , date a | nd place, | and due to | the cause(s) | |
| To the within 2 To the complet | Σ | 29b. Signature and title of certifier | 1/200 | | | | number | | 29d. D | ate signe | d (Month, | Day, Year) | |
| | | medy ! | nysician | 7 | U | 000 | 24728 | - | Nov | remb | er 2 | 6,2006. | |
| 3 | | 30. Name and address of persol who co | ompleted cause of death (Item Ke, JR, MO, 9(| 23a) (Typ | oe, Print) | N A | tve RA | Him | 00 | mn | 217 | 229 | |
| State | e_ | 31. Date filed (Month, Day, Year) | 32. Registrar's Signa | (019 | | F | 12V | () () () | ١٠٠١ | , | | | |
| Registra | _ | NOV 2 8 20 | 06 Strange A | E A | and I | | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5 Per FH gob 1/26/07 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day NOVEMBER 24, Year 2006 9:39pM **Physician** ALISON ARDEN WHARTON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GILCHRIST TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Ochtonth, Days | Pearl 9 , 1 9 2 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 312-26⁶-7623 1 □ M 💥 □ F 81 Yrs Director CALIFORNIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ms 23a or 28a-f show must be notified at Director MD BALTIMORE RUXTON 1 ☐ Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1307 BERWICK ROAD 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items: any Injury or other traumatic event, the Medical Ex. miner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARALD deROPP MARGARET TRIMBLE ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ST. TIMOTHY SCHOOL STEVENSON, MD 21153 19a. Informant's Name/Relationship (Type. Print) LOUISE PISTELL daughter Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GREEN MOUNT BALTIMORE, MD 11/28/2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 21. Signature of 16924 YORK RD. MONKTON, MD 21111 23a. Part1. Enter the disease, or cor shock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MIXE Dwells disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Physician/Medical Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? þ barbitudo 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an funeral director, page 2 autopsy 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Yes 2□ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 12/2006 1 🗌 Yes ested vanous meas estu death 2 Accident 24 hours after death Funeral Director: filled in by the Place if injury - At home, fam () reet, factory, office building, etc. (Specify) 28f. Location (Set and City or Town, State) 3 Suicide 4 ☐ Homicide 6 Could not be determined and Number or Rural Bot Benuch Tome 2130 Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2, 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Registrar

6601 N FaullmerND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pegiştrar's Signature

W (Kner MY)

haveost/Balto MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** atherine 2006 1505 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** clal Mederal buse brund If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 ☐ M 2 🖫 F Months Days Hours Min. 216-20-6641 79 Director Dec. 21, 1926 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits oriant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other treumatic event. The Modical Examiner must be notified at 1 Tes 2 X No Director MD Kent Chestertown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 22570 Bayshore Rd. 21620 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be flied within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumatic event Elementary/Secondary (0-12) College (1-4or 5+) Clothing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin Dungan Gladys Lowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Clifford Wilson / Son 22570 Bayshore Rd., Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 20, ¥2¥Burial 2 ☐ Cremation 3 ☐ Removal from State November * 4 □ Donation 5 □ Other (Specify) 2006 Elkridge, MD Meadowridge Memorial 21. Signature 22. Name and Address of Facility 1 Second Ave. M01411 Singleton Funeral Home, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** day S /Medical Due to (or as a consequence of): Chile Cole Examiner lostridia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed the burial-transit and Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year detached for Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Corana desea. page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has 1 Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: ral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 Yes Certification: To 1 MInpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. 28d. Describe how injury occurred Injury at Work? After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) l in by 1 4 | Homicide 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO DOO 61783

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address deperson who completed cause of death (Item 23a) (Type, Print)
Chang Char, 2001 Middle Pkwy,

32 Registrar's Signature

Chur,

NOV 2

8 2006

31. Date filed Month, Day, Year)

| | | For | State of Ma | aryland / | | | | nd Mental H | lygiene | | | |
|--|---------------------|---|--|--------------------|-------------------|--|---|--|-----------------------------|--|---------------------------------------|----------------------|
| | | 1 - State Registrar | | | Certi | ficate of I | Death | | Reg. No. | 2000 | 3 37 | 631 |
| Physic /Medi | | 1. Decedent's Name (First, Middle, La James | st) | Will | oer | | | 2. Date of Month Novem | | 5,2006 | 3. Time o | of Death |
| Exami | | 4a. Facility Name (If not institution, giv | · · · · · · · · · · · · · · · · · · · | | 4 | lb. City, Town, or | r Location of I | Death | 4c. | County of Dear | th | |
| | | 7466 E. Furnace | | | | Glen | Burnie | | | nne Aru | | |
| Funeral Director | | | ex 7. Age | e (In yrs. last bi | | Months Days | | Min. 8. Date of (Month, March | Day, Year) 26,1 | 936 9. Birt | hplace (State buntry) CO | or Foreign |
| land t | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Tow | vn or Loca | tion | | | | | 10d. Inside C | City Limits |
| Maryl -f sho | ō | MD Anne Ar | undol | G1en | Duren | | | | | | | 2 X No |
| r 28a | irec | 10e. Street and Number | under | Gren | DUI II. | 10f. Zip Code | | | 10g. Citi | zen of What Co | untry? | |
| th with | a D | 7466 E. Furnace | Branch Roa | d #205 | | 21060 | | | U.S. | .A. | | |
| aryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "ratural", or Items 23a or 28a-f show imatic event, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced | 12. Was Decedent B Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates: | | 1 | s Decedent of H 'es, specify Cuba Yes 2 No | lispanic Origir an, Mexican, F Specify: | n? (Specify Yes or Puerto Rican, etc.) | | Race - Ame Black, White Specify: | | |
| 21215-0036 d within 72 hours af giene. r than "natural", or the Medical Exami | ted | 15. Decedent's Ed | ducation | 16a | a. Deceder | nt's Usual Occup | ation | f | 16b. Kir | nd of Business/ | Industry | |
| 215 thin 7 an "r Med | ple | (Specify only highest gra Elementary/Secondary (0-12) | College (1-4or 5 | +) | _ | nd of work done of NOT use retired | during most o | t working | | | | |
| 21 ed wii ygien ygien t, the | Completed | | 4 | | Car | pentry | | | | nstruct | ion | |
| <u> </u> | Be | 17. Father's Name (First, Middle, Last, Fred Wilber |) | | | | | Name (First, Midd | | Surname) | | |
| arylan should be nd Mental marked o | 은 | 19a. Informant's Name/Relationship (| Tuno Print) | 100 | h Mailina | Addroso (Street | | red Cleav | | - T Otata | | |
| Manuth and traum | | Mrs. Kathryn Will | | 1 | | | | Severna | | | | |
| | | 20a. Method of Disposition | | 20b. Place o | of Dispositi | on (Name of | | ov. 19, | | cation - City or | | |
| Sattmore, bermit. Pages 1 ar Department of Hea mportant: If Item i any Injury or other ance. | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif | | 1 . | - | tory or other place Cremat: | | ov. 19, 2006 | Stev | ensille | MD | |
| Baltimo permit. Page Department Important: If any Injury or once. | 1 6 | 21. Signature of Funeral Service Licer | · | 1 | - | | | Singleto | | | - | Α. |
| o a le c | | 1 | | MO1459 | | | | SW Glen H | | | | |
| Physician /Medical Examiner | , | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, | a. Probos bue to (or as a | e my(| of): | the moder of dyin | g, such as ca | rdiac or respiratory | arrest, | | Approxima Interval Be Onset and | te tween Death |
| ted 1sit | nine | il any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a | a consequence | or). | | | | | | | |
| 58 / 60, icate be executed physician and s the burial-transit | Examiner | that initiated events resulting in death) Last | c Due to (or as a | a consequence | of): | | | | | | - | |
| 8760 ate be e physiciar the buria | dical E | | d | | | | | | | | | |
| | ledi | | | | | | | | | | | |
| , P.O. BOX 6 that the death certific red by the attending p detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | | 23d. Date Mont | | | Year | | | | | |
| Hecords, P The law requires that the has been signed b bage 2 should be deta | by P | Part II. Other significant conditions of | | | | ^ | | 23e. Di | d tobacco us | se contribute to | the cause of | death? |
| VITAI KECONGS, sician: The law requires t certificate has been signe rector, page 2 should be c | ed | HISTORY of IFF | T CERUBA | OVASCUL | ti K_ | HICHEL | AT | _ 10 | Yes 2 | No 3∏Pr | obably 4 🗆 | Unknown |
| ecc law r as be | Completed | History of HYV | EKTE IVI | MON | | | | 24a. Wa | as an topsy | 24b. Were au | topsy findings completion of c | available |
| | 100 | History of HYP | GRLIFIUEI | (9H) | | | | pe 1□ Yes | rformed? | death? | 2 □ No | ause or |
| r VITa ysician; ysician; iis certific director, | Be (| 25. Was case referred to medical examiner? | 11 | | | | | Death (Check onl | y one) | | | |
| Or VITA Physician: rthis certific ral director, | 은 | 1 Yes No | Hospital: 1 ☐ Inpatie | | | 3□ DOA Othe | 4 LI Nursi | ng Home Re | | | cify) | |
| Ing Ing | ion: | 1 Natural 5 ☐ Pending | 28a. Date of Injur (Month, Day | | Time of Injury | 28c. Injun Work | y at ⟨? Yes 2 □ No | 28d. Describ | e how injury | occurred | | |
| INISION I or Attending after death. Director: After in by the fune | ficat | 3 Suicide 6 Could not be | | ry - At home, fa | arm, street | | 163 Z [] 140 | | (Street and | d Number or Ru | ral Route Nun | nhe r |
| all or al | Certification: | 4 Homicide determined | building, etc | (Specify) | | | | City or 1 | own, State) | | | |
| DIVISIO To the Hospital or Attend within 24 hours after death. To the Funeral Director: / | Medical C | 29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam | ysician: To the best on niner: On the basis of and manner sta | examination at | e, death o | ccurred at the tin | ne, date and p pinion, death | place, and due to the control occurred at the time | ne cause(s) ne, date and | and manner as place, and due | stated. to the cause(| s) |
| To the within To the comp | Me | 29b. Signature and title of Certifler | MA Yaya | | | 29c. License | number 277 | 1 | 29d. Date | e signed (Mont | , Day, Year) | |
| 17 | | 30. Name and address of person who | | eath (Item 23a) | (Type, Pri | nt) | 3031 | | | 1/2/0 | D | |
| 6 | | 8028 Ritchie High | | | | | Ian | K. Slepi | lan | | | |
| | ate | 31. Date filed (Month, Day, Year) | 32. Registra | r's Signature | | | | | | | | |
| Regist | | NOV 2 8 2 | 006 | J. St. | Apar | as I | | | | | | |
| DHMH 17 Rev 1/2 | c(R)1 | | Marie Control | | W | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene UUD For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Arthur Fletchall Woodward 24, 2006 0740 November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital 01nev Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 1 M 2 □ F Yre 1920 Maryland 86 17, Director June 212-34-2409 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ehow 27 is marked other than "natural", or itame 23s or 28s-f ebov traumatic avent, the Medical Exercicer must be notified at 1 Yes 2 No Montgomery Rockville Maryland Direct the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 115 North Van Buren Street 20850 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No 1946 — If Yes, Give Year or Dates: 1949 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Medical Practice Physician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 end 2 should be fill ment of Health and Mental H ant: if item 27 is marked other. Be Clarine Fletchall 2 Charles W. Woodward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20850 115 N. Van Buren Street, Rockville, Maryland Elizabeth H. Woodward/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State November 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: if any injury or once. y Cemetery 27, 2006 Beallsville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 27, 2006 4 ☐ Donation 5 ☐ Other (Specify) Monocacy Cemetery 21. Signature of Funeral Service Licenset plues Mullian M01173 4. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Weeks disease or condition resulting in death) Acute Myelogenous Leukemia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I ed by the a 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificete has t lirector, page 2 s Hospital or Attending Physician: After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural s effer dec. aj Diractor: Atte 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours el To the Funeral D completely filled i 29s. Curtifier Medical Certifying Physicians To the best of my knowledge, death occurred at the time, date and place, and due to the neuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42452 November 24, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Drive, #327, Olney, Maryland Chitra Rajagopal, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 8 2008 A popular Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Completed

Be 2

Examine

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

the Medical

Department of Health a Important: If item 27 is any injury or other tra

Physician

/Medical

Examiner

burial-transit and

the

attending physician

that the death certificate be executed

Box 68760.

Division or Vital Records, P.O.

Baltimore, Maryland 21215-0036

Certificate of Death 1. Decedent's Name (First, Middle, Last) Elizabeth Whittaker

Rea. No. 2. Date of Death Month 22, P MNovember 2006 3:51

4b. City. Town, or Location of Death

4c. County of Death

Shady Grove Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🕅 F

Rockville Montgomery | Months | Days | Hours | Min. | 8. Date of Birth (Month, Days Year) | 9. Birthplace (S (Month, Days Year) | Virginia 9. Birthplace (State or Foreign

Usual Residence of Deceden 10h. County

10c. City. Town or Location

89

10d. Inside City Limits

1 X Yes 2 □ No

Maryland Montgomery

Rockville 10f. Zip Code

10g. Citizen of What Country? United States

14 Grandin Circle

 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify

14. Race - American Indian. Black, White, etc. White Specify.

3 K Widowed 4 □ Divorced

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

20851

16b. Kind of Business/Industry

Elementary/Secondary (0-12)

College (1-4or 5+)

Teacher

Education

17. Father's Name (First, Middle, Last)

Alfred Frank DeBusk

Mattie Robinette

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 436 Uvilla States Drive, Shenandoah Junction, WV 25442 Date

2006

Charles R. Whittaker, Jr./Son 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park

20c. Location - City or Town, State November 27, Rockville, Maryland

4 □ Donation 5 🗴 Other (Specify) Intombment 21. Signature of Funeral Service Licenses

1 ☐ Burial 2 ☐ Cremation

Millian

M01173

Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 23a. Part1. Enter the disease, or complications may caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Immediate Cause (Final disease or condition resulting in death)

Aspiration Pneumonia Due to (or as a consequence of):

Approximate Interval Between Onset and Death Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| | 0 | st | : 6 | 0 | рo | r | 0 | S | i |
|----|-----|----|-----|-----|-----|-----|-----|-----|----|
| to | (or | ac | a | con | ean | 110 | nce | 2 / | าก |

Due to (or as a consequence of)

Years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

Due

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

Hypertension, Congestive Heart Failure,

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Year

Osteoarthritis

24a. Was an autopsy perform 1□ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

2X No 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

27. Manner of Death 5 Pending

investigation

6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of Injury at Work? Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a, Certifier (Check only one)

1X Natural

2 ☐ Accident

3 ☐ Suicide

4 Homicide

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated

29c. License number 64407 29d. Date signed (Month, Day, Year) November 22, 2006

20850

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical Center Drive, Rockville, Maryland Rebecca Barker, M.D.

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

To the Hospital or Attending within 24 hours after death.

within 24 hours a To the Funeral D

Director:

The law requires that the death certificate be executed P.O. Box 68760. Records, Division of Vital Hospital or Attending Physician:

attending physician

been

death.

ţ

within 72 hours after

should be filed within and Mental Hygiene.

Maryland 21215-0036

Baltimore,

within 24 hours aft To the Funeral Di completely filled in

State Registrar

Medical

Ravi Passi, M.D. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

4 Homicide

29b. Signature and little of certifier

WSS

29a. Certifie

15225 Shady Grove road #404B, Rockville, Maryland 20850 2006

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D28656

29d. Date signed (Month, Day, Year)

November 20, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** WILKS JEANETTE 16 2006 1:30p. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1300 E. Lanvale St. Apt. 332 N/A Baltimore Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2**x3x**F 220-54-7881 11-9-1951 55 Md. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State iral", or Items 23a or 28a-f show Examiner must be notifled at 1X Yes 2 No N/A Baltimore Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21213 1300 E. Lanvale Street Apt. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: if flem 27 is marked other the any Injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married 2 No 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Social Security Administration Federal Gov. yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilks, Sr. Emma Roane Charles Thomas 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vancouver Road, Baltimore, Md. 21229 Shelia Wilks Sister 4722 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Rurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Carmel Cem. 11-27-06 Dundalk, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 0 Warren 21202 1101 E. North Avenue Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the sid be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2X No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes certificate 1∐ Yes 2□ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 1XYes 2 No 2 ER/Outpatient 3□ DOA 1 | Inpatient 5 Residence 6 Other (Specify) မ After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

4

31. Date filed (Month, Day, Year) NOV 2 8 2006

vette Leslie Kasamon, M.s. 401 North Broadway. . Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

November

Baltimore

17, 2006

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 37635

| | | 1- For State Registrar | | Cer | tificate of | Death | | | Reg. No. | | | | | |
|--|----------------|--|--|---------------------|-------------------|-------------------------------------|-----------------|------------------------|-----------------------|---|--|--|--|--|
| Physicia | | Decedent's Name (First, Middle) | | | | | | 2. Date of De Month | eath | 3 Time of Death | | | | |
| ledical Exami | ner | Richard | | Wetherin | ngton | | | Novemb | er 25, 2006 Yea | 0645 hrs | | | | |
| | | 4a Facility Name (if not institution Baltimore-Washington | | umber) | 1 | 4b. City, Town, or L Glen Burnie | ocation of Deat | h | 4c. County of Anne Ar | | | | | |
| Funeral | | 5. Social Security Number | 6 Sex | 7. Age (In yrs Ia | ast birthday) | If Under 1 Year | If Under 24Hr | s. 8 Date of E | Birth (MM/DD/YYYY | 9 Birthplace (State or | | | | |
| Director | | 214-50-7915 | 1 X M - 2 F | | 59 Yrs | Months Days | Hours Mil | 10/ | 15/1947 | Foreign Country) MD | | | | |
| | | Usual Residence of Decedent | | | 33 | 1 | <u> </u> | 1 10/ | 13/134/ | TID | | | | |
| any | | 10a State 10b. County | | 10c. City, | Town or Locat | ion | | | | 10d thside City Limits | | | | |
| 5 | _ | Maryland Anne | yland Anne Arundel Glen Burnie | | | | | | | | | | | |
| daryland 28a-f show | ctc | 10e. Street and Number | 711 411461 | | | 10f. Zip Code | Durine | | 10g. Citizen of Wh | nat Country? | | | | |
| th the Maryland 23a or 28a-f sho notified at once. | Director | 1604 Pleasant | ville Dri | Ve | | | 21061 | | | UCA | | | | |
| with 1 | | 11, Marital Status | | cedent Ever in U. | S. 13. Wa | s Decedent of Hispa | | Specify Yes or N | No- 14 Race | USA 14 Race - American Indian, Black, | | | | |
| eath item ust b | Funeral | 1 Never Married 2 X Ma | arried Armed F | | | es, specify Cuban, | | | White | | | | | |
| fter d | | 3 Widowed 4 Div | orced If Yes, Give Ye | 2 X No | 1 | Yes 2 X No | specify: | | Specify | White | | | | |
| ours a | d by | 15. Decedent's Education (Spe- | or Dates: cify only highest gra | de completed) | | t's Usual Occupation | | | 16b Kind of Bu | | | | | |
| 72 hc | ete | Elementary/Secondary (0-12) | College (| 1-4 or 5+) | during m | ost of working life. [| DO NOT use re | tired) | i | | | | | |
| 5-0036 lled within 7 Hygiene I other than | Complete | 8 | | | | 0wner | | | Janito | rial Service | | | | |
| 5-0 Sled v Flygir | | 17 Father's Name (First, Middle, | | | | 18 | | | , Maiden Surname) | | | | | |
| 21215-0036 Juld be filed within 7. Mental Hygiene marked other than c event, the Medical | Be | Shepard B. | | rington | | | Doris | | | urn | | | | |
| Ogbig | 5 | 19a Informant's Name/Relations Beverly L. Wetl | 1 3 71 / | 100000 | | | | | umber, City or Town | | | | | |
| | | 20a Method of Disposition | ner riig con | | | Ition (Name of ceme | tville | Dr., Gl | <u>en Burni</u> | e, MD 21061 | | | | |
| altimore, mit Pages lan partment of Hee pportant: If itel inry or other tr | | 1 Burial 2 X Cremation | n 3 Removal f | | rematory or oth | | | :. 01 | 20c Location - | City or Town, State | | | | |
| 등 교육 등 글. | | 4 Donation 5 Other Sp | | Met | cro Crei | natory In | c. | 2006 | Baltim | ore, Maryland | | | | |
| Baltimore, Permit Pages I and Department of Healt Important: If item injury or other trau | | 21. Signature of Funeral Service | Signature of Funeral Service Licenses 22. Name and Address of Facility Stallings Funeral | | | | | | | | | | | |
| | | 23a Part I Enter the disease, or complications that caused the gears. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart | | | | | | | | | | | | |
| Physician /Medical | | 23a Part I Enter the disease, or failure. List only one cause | on each line. | aused the death. | Do not enter the | ne mode of dying si | uch as cardiac | or respiratory a | rrest, shock, or hea | Approximate Interval Between Onset and | | | | |
| Examiner | | Immediate Cause (Final disease | | | | scular dise | ase | | | Death | | | | |
|) | | or condition resulting in death) | Due to (or as a | a consequence of | f): | | | | | | | | | |
| - | ē | Sequentially list conditions, if any, leading to immediate | Due to (or as | a consequence of | ·): | | | | | | | | | |
| | Ë | cause. Enter Underlying Cause (Disease or injury that initiated | Č. | | | | | | | - 34 | | | | |
| V 93 15 | Examine | events resulting in death) Last | Due to (or as a | a consequence of | F) | | | | | | | | | |
| executed an and al - transi | | LINDENDED | X AMENDED | #6 perH | 1 (262 | 12/22/Q6_TI | ٠ | | | | | | | |
| | n/Medical | X UNPENDED | | #23a.27.r | xerME.g8 | 62, 12/11/0 | 6 TT | | | | | | | |
| 376 ficat g phy s the | N. | IF FEMALE: 23b Was decedent pregnant in the | ne 23c. If yes, | outcome of pregr | nancy 2 Fe | tal death 3 | Ectopic pregn | ancy | 23d Date of Month | delivery Day Year | | | | |
| | cia | past 12 months? | 4 Pregr | nant at time of dea | oth | ner (Specify) | _cetopic pregn | aricy | Worter | Day Teal | | | | |
| Box e death c the atten ed for us | Physicia | 1 Yes 2 No 9 Unk | known 9 Unkn | own | 0. | 101 (+,+++-)/ | | | | | | | | |
| P.O. Box 68 s that the death ccrtigned by the attending cetached for use a | P | Part II. Other significant condit | ions contributing t | o death but not re | esulting in the u | nderlying cause giv | en in Part I. | 23e Did | tobacco use contri | bute to the cause of death? | | | | |
| ires that signed | d by | | | | | | | 1 Y | es 2 No 3 | Probably 4 🗸 Unknown | | | | |
| Records, The law require | Completed | | | | | | | 24a. Wa | | Vere autopsy findings available rior to completion of cause of | | | | |
| eco ne law te has ge 2 s | Ę. | | - | | | | | perf | formed? d | eath? | | | | |
| tal Recision: The | | 25. Was case referred to medica | | | | 26 Place o | f Death (Check | 1 Yes | 2 No 1 | Yes 2 No | | | | |
| Division of Vital rate or Attenting Physician: rs after death al Director: After this certical on the funeral director |) Be | examiner? | Hospital: | Inpatient 2 | ER/Outpatient | | ther: | ng Home 5 | Residence 6 | Other | | | | |
| of \ ng Phy After th | <u>۔</u> | 27 Manner of Death 28a Data of Injury 29b Time of Injury 29c Injury of Mark 2 29d Death by Death by Death Bull 29d Death by Death Bull 29d De | | | | | | | | | | | | |
| ath Fe fur | tion | 1 Natural 5 Pending (Month, Day, Year) | | | | | | | | | | | | |
| iSic | ica | 2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number of Rural Route Number or Rural Route Nu | | | | | | | | | | | | |
| Div ital or ital Div | Certification: | | mined (Specify) | | | • | O. | or Town, | | , | | | | |
| Division of Vital Records, P.O. Box 6 Hospital or Attenting Physician: The law requires that the death cet 24 hours after death Finneral Director: After this certificate has been signed by the attendi | | 29a Certifier | nysician: To the be | st of my knowledg | ne death occur | red at the time, date | and place and | d due to the car | use(s) and manner | as started | | | | |
| Division To the Hoopital or Attent within 24 hours after death To the Finneral Director: completely filled in by the | Medical | | miner:On the basis | of examination ar | | | | | | | | | | |
| To COT | Me | 29b. Signatule and title of certifie | and manner s | stated | | 29c License | number | | 29d Date signe | ed (Month, Day. Year) | | | | |
| | | 100 | 1) De M. | (11) | | O.C.M | .E. | | November 2 | 25, 2006 | | | | |
| | | 3 Name and a triss of person | who completed cau | se of death (Item | 23a) | | | | | | | | | |
| 10 | | | ssistant Medica | | | Street, Baltimo | ore, MD 212 | 201 | | 1 | | | | |
| S | ate | 31. Date filed (Month, Day, Year) | 32. R | | re / | | _ | | | | | | | |
| Regis | | NOV 2 | R 2006 | diame. | A FE | الكان | | | | / | | | | |

| | | | Please T | ype or Prir | | | | | - | | _ | |
|--------------|--|-----------------|--|--|--|-----------------------|---|---|--|---|--------------------------------------|--|
| | | | For State | State of Ma | aryland / I | | | lealth and N | ∕lental Hy | - | 0000 | 27626 |
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | | | Cer | tificate of | Deam | 2 Date of De | Reg. N | 6000 | 3. Time of Death |
| | Physici | | NATHAN | | | | WEINBERG | 2 | Month | D | 75 100 | - 20 |
| | /Medic Examin | | 4a. Facility Name (If not institution, give s | treet and number) | | | | r Location of Death | | | 25,200 (c. County of De | |
| | | | Sinai Hospital | of Bal | timore | 2 | Baltim | lore Cit | Y | | N/A | 4 |
| | Funeral | SE S. | 5. Social Security Number 6. Sex | 7. Ag | e (In yrs. last bii | | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da 04/22/ | rth ay, Yea | 9. Bi | rthplace (State or Foreign ountry) |
| 7 | Director | | 217-16-8801 X | | 89 | Yrs. | | | 04/22/ | 191 | / | MD |
| | anyland ehow | | 10a. State 10b. County | | 10c. City, Tow | | | | | | | 10d. fnside City Limits |
| | e Mar | ctor | MD BALTIMO | RE | BA | LII | MORE | | | | | 1 ☐ Yes 2 No |
| | or 28 | Director | 10e. Street and Number | _ | | | 10f. Zip Code | | | - | Citizen of What C | ountry? |
| | death with the Maryland ms 23s or 28s-f show rmust be notified at | erai | 20 STAGS LEAP COU | RT 12. Was Decedent | Cues in II C | 10.1 | 21208 | lianania Osinia 2 (Ca | and Van an Na | | U.S.A. | odoon Indian |
| 326 | or its | by Funerai | 11. Maritaf Status 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 Yes 2 ! ff Yes, Give Year or Dates: | | 1 | Yas Decedent of H Yes, specify Cuba | lispanic Origin? (Sp an, Mexican, Puerto Specify: | Rican, etc.) | o- | Black, Wh | |
| 15-0036 | "natural", | Completed | 15. Decedent's Educ (Specify only highest grade | cation | 16a | | lent's Usual Occup | ation during most of work | king | | Kind of Busines | • |
| Z | within 72 he jene. r then "natu | mpie | Elementary/Secondary (0-12) | Coflege (1-4or 5 | | life. L | OO NOT use retired | d) | | | | JEANETTE |
| N | filled v Hygie other t | | 12 17. Father's Name (First, Middle, Last) | | TRU | ISTE | E AND VI | CE PRESID 18. Mother's Nam | | | | FOUNDATION |
| and | d ai | To Be | JOSEPH | | WEINB | RFRG | | SARAH | | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | KAMMEI | RMAN |
| ary | shound M | H | 19a. Informant's Name/Relationship (Ty) | oe, Print) | | | g Address (Street | and Number or Ru | ral Route Numb | er, City | | |
| , Mar | and 2 salth a n 27 is | | LILLIAN WEINBERG | / WIFE | | | | P COURT - | BALTIM | IORE | , MD 212 | 208 |
| Baitimore, | t and the state of | | 20a. Method of Disposition 1 Disposition 2 Department 3 DR | emoval from State | 20b. Place o cemete | of Dispo Iry, cren | sition (Name of natory or other plac | ce) | Date | | Location - City o | |
| | t. Pag trmen trant: | | 4 □Donation 5 □Other (Specify) | 1 | HAR SIN | | | | | | NGS MILI | |
| g | permit. Page Department of Important: if eny injury or once. | | 21. Signatur of Funeral Service Licente | 11100. | | | | ss of Facility SO | | | | , INC. , MD 21208 |
| ĕ | * , | | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or | cations that caused | the death. Do | | | | | | LJVILLL | Approximate |
| | rnysician /Medical | | snock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) | Pneumo | nia | | | | | | | finterval Between Onset and Death 2 days |
| | Examiner | | | Due to (or as | a consequence | of): | | | | | | |
| -50 | | Jer | Sequentially fist conditions, if any, feading to immediate cause. Enter Underlying | | a consequence | of): | | | | _ | | |
| | aath certificate be executed attending physician and for use as the buriat-transit | Examine | that initiated events | | | | | | | | | |
| ç Q | be exe ician a buriat- | ai Ex | resulting in death) Last | Due to (or as | a consequence | of): | | | | | | |
| 789 | physic | dica | Q d | | | | | | | | | |
| | death certificate e attending phys od for use as the | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant | 3c. ff yes, outcome | | | | | | | 23d. Date of de | alivery |
| gox. | death e atter d for u | iciar | in the past 12 months? | 4 Pregnant at | 2 Fetal death time of death | | Ectopic pregnancy Other (specify) | <i>'</i> | | | Month | Day Year |
| J. | that the ed by the detache | hys | 9 🗆 Unknown | 9∐ Unknown | | | | | - | | | |
| ທົ | Se Cao | | Part II. Other significant conditions con | | | | | | | | 1 | o the cause of death? |
| 0.0 | een s | eted | Aortic Stenosis, K | nem u i e | 1710101 | (1) | Hypert | MUTOFI | | | | robably 4 Unknown |
| Vital Record | e la has je 2 | Completed by | | | | | | | 24a. Was auto perfe | | prior to | utopsy findings available completion of cause of |
| <u> </u> | ician: Th certificate rector, pag | e Co | 25. Was case referred to medical | | | | | 26. Pface of Dear | 1 Yes | 200 | lo 1 □ Ye | s 2 No |
| | | To B | examiner? | ospital: 1 Inpatie | ent 2 ER/O | utpatien | t_3 DOA Oth | 25 | | | 6 ☐Other (Sp. | ecify) |
| 0 | ding Phys h. After this funeral di | | 27. Manner of Death 1 Naturaf 5 ☐ Pending | 28a. Date of Inju (Month, Da | ry 28b. | Time of | 28c. Injur Wor | | 28d. Describe | _ | | |
| <u> </u> | en en or: he | cati | 2 Accident investigation 3 Suicide 6 Could not be | | | | M 1 🗆 | Yes 2 ☐ No | | .= | | |
| DIVISION | - 9 | Certification: | 4 Homicide determined | 28e. Place of Inj building, et | ury - At home, fa c. <i>(Specify)</i> | arm, str | eet, factory, office | | 28f. Location (City or To | | | lural Route Number, |
| | To the Hospital o within 24 hours aft To the Funeral Dicompletely filled in | edical C | 29a. Certifier (Check only one) | iician: To the best ter: On the basis of and manner st | f examination ar | e, death | occurred at the tir restigation, in my o | me, date and place, pinion, death occur | and due to the red at the time, | cause(| (s) and manner a nd place, and du | s stated. e to the cause(s) |
| | To the within To the | Me | 29b. Signature and title of certifier | | | | 29c. Licens | e number | | | ate signed (Mon | |
| | | | Ville & M | frau | W | | RES | -000 | | NOV | imber : | 15,2006 |
| | 20 | iii | | eted cause of d | | | | 1 0-11. | 10001 | | | |
| -6 | 0 | | Eileen S. Zingy 31. Date filed (Month, Day, Year) | | ar's Signature | ii t | ospital | of Balti | more | | | |
| 1.7 | Sta | te. | ,,, | J. Ingisti | | B | 100 | | | | | |

DHMH 17 Rev 1/2001

NOV 2 8 2006

Registrar

parks

| | | 1 | For State Registrar | State of Marylan | | | of Health and I Sof Death | | giene Reg. N2 006 | 37637 | | | | |
|---------------------|--|----------------|---|--|------------------------|----------------------------------|--------------------------------------|---------------------|------------------------------|---|--|--|--|--|
| | | | Decedent's Name (First, Middle, Las | st) | | | | 2. Date of Dea | ath | 3. Time of Death | | | | |
| | Physicia /Medic | | Charles Everett | Yates II | | | | Novemb | er 23, 200 | | | | | |
| | Examin | | 4a. Facility Name (If not institution, give | | | | m, or Location of Death | h | 4c. County of Death Harford | | | | | |
| | | | 200 R Secretaria | | to an initial of a li | | de Grace | O Date of Birt | | I Birthplace (State or Foreign | | | | |
| | Funeral Director | | 5. Social Security Number 6. Social Security Number 1. | ex 7. Age (In yrs. X 59 | Yrs. | | ays Hours Min. | April | $12^{\frac{h}{\chi}}$ 1947 V | Country) WA | | | | |
| | 2 | H | Usual Residence of Decedent | 140-0 | T | | | | | 10d. Inside City Limits | | | | |
| | ehow | | 10a. State 10b. County | 106. Cit | ty, Town or Lo | | _ | | | 1 ☐ Yes 2 ☐ No | | | | |
| | M Pie M | Director | Md. Harfor 10e. Street and Number | d | На | vre de | | | 10g. Citizen of What | | | | | |
| | with with the control of the control | 급 | 200R Secretariat | Drive | | | 21078 | | U.S.A. | o o o o o o o o o o o o o o o o o o o | | | | |
| | ne 23 | Funeral | 11. Marital Status | 12. Was Decedent Ever in U | .S. 13. | Was Decedent | of Hispanic Origin? (S | pecify Yes or No- | | merican Indian, | | | | |
| 336 | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Intropriant: If then 27 is marked other than "netural; or items 23s or 28s-f show eny injury or other traumatic event, the Machinal Examiner must be notified at 800cs. | by Fur | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | | if Yes, specify 1 ☐ Yes 21X | Cuban, Mexican, Puerl No Specify: | to Hican, etc.) | Specify: | thite, etc. white | | | | |
| Ŏ I | 2 ho | Completed | 15. Decedent's Ed | ducation | 16a. Dece | dent's Usual O | ccupation one during most of wo | rking | 16b. Kind of Busine | ss/Industry | | | | |
| 2 | ithin / | nple | Elementary/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use r | etired) | 9 | . 1 | | | | | |
| 7 | ygien ygien ner th | | | 4 | techr | ical m | | no (Fina Adiada | chemist | ТУ | | | | |
| Maryland 21215-0036 | d be fill | m | 17. Father's Name (First, Middle, Last) Charles E. Yates | | | | | ne Brown | Maiden Sumame) ing | | | | | |
| کّ | should nd Me mark imati | 2 | 19a. Informant's Name/Relationship | | 19b. Maili | ng Address (S | reet and Number or Ru | ural Route Numbe | er, City or Town, Stat | e, Zip Code) | | | | |
| Z, | and 2 alth a 27 io | | Donna Rae Yates/ | wife | 200H | Secre | tariat Dri | ve, Havr | e de Grace | e, Md. 21078 | | | | |
| Baltimore, | Pages 1 and of He out: If item ry or oth | | 20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Specify | Removal from State Mou | cemetery cre intain | natory or other Christ | rplace) ian | Date / 27 / 2006 | Joppa N | | | | | |
| ati | partm porta y inju | | 21. Signature of Fund 1 Service Lice | 563 Cm | 2: | | ddress of Facility | II 6 | Dal Adm | Tno | | | | |
| m | 80 5 8 | | Sym Osman | y | | chimun | ek Funeral MacPhail R | Home of | Air. Md. | 21014 | | | | |
| | | | 23a Ferti. Enter the disease, or com shock, or heart failure. List only | plications that caused the deat one cause on each line. | th. Do not en | ter the mode o | dying, such as cardia | c or respiratory ar | rrest, | Approximate Interval Between Ofiset and Death | | | | |
| | Physician | | disease or condition | a nietast | atic | me | Sucous | | | 1000 | | | | |
| | /Medical Examiner | | resulting in death) | Due to (or as a consec | | | | | | | | | | |
| | | er | Sequentially list conditions, if any, leading to immediate | b. Due to (or as a consec | uence of): | | | | | | | | | |
| 9. | nted Insit | min | cause. Enter Underlying Cause (Disease or injury | | , | | | | | | | | | |
| ر ا | execu en and rial-tre | Exa | that initiated events resulting in death) Last | Due to (or as a consec | quence of): | | | | | | | | | |
| 8760, | icate be executed physicien and s the burial-transit | dicai Examin | | d | | | | | | | | | | |
| ي × | ertific ding p | | IF FEMALE: | 23c. If yes, outcome of pregn. | anov | | | | 004 8-4-4 | d-15 | | | | |
| Вох | death certific le ettending p ad for use as | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth 2 ☐ Feta | al death 3 | ☐Ectopic pregr ☐ Other (speci | - / | | 23d. Date of Month | Day Year | | | | |
| o. | 0 0 | ysle | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9☐ Unknown | | | // | | | | | | | |
| Δ. | es Ped | <u>م</u> | Part II. Other significant conditions of | contributing to death but not res | sulting in the u | nderlying caus | e given in Part I. | 23e. Did to | \- | e to the cause of death? Probably 4 []Unknown | | | | |
| Ö | v requir been s should | ete | | | | | | 24a. Was | an 24h Were | autopsy findings available | | | | |
| α | 9 <u>-</u> 2 | Completed | | | | | | autop perfo | osy prior death | to completion of cause of | | | | |
| | ilcien: Th certificete rector, pag | BeC | 25. Was case referred to medical | | | | 26. Place of De | ath (Check only o | | 103 213110 | | | | |
| ⋛ | Ø 2. ₹ | ToB | examiner? 1 □ Yes 2 □ No | Hospital: 1 Inpatient 2 |] ER/Outpatie | nt 3 DOA | Other: 4 Nursing | Home 5 Resid | dence 6 Other (5 | Specify) | | | | |
| | | | 27. Manner of Death 1- Natural 5 Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time o Injury | | Injury at Work? | 28d. Describe I | how injury occurred | | | | | |
| <u>s</u> | Attending r death. ector: After by the fune | cati | 2 Accident investigation 3 Suicide 6 Could not b | | | М | 1 Yes 2 No | 206 Lanning (| Charles and Alicenters | S - 1 S - 1 N - 1 | | | | |
| Division | l or At after o Direct in by | Certification; | 4 Homicide determined | 28e. Place of Injury - At h building, etc. (Speci | iome, tarm, st fy) | reet, factory, o | flice | City or Tox | | r Rural Route Number, | | | | |
| _ | To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the | | | nysician: To the best of my kn | | | | | | | | | | |
| | the Ho hin 24 th the Fu npletely | edicai | (Check only 2 Medical Exar | niner: On the basis of examination and manner stated. | ation and/or in | vestigation, in | my opinion, death occ | urred at the time, | date and place, and | due to the cause(s) | | | | |
| | vithin 2 To the | Σ | 29b. Signature and title of certifier | 21/1/12 | \sim | 29c. L | icense number | | 29d. Date/signed (M | dnth, Day, Year) | | | | |
| • | د. | | Dichar J | HICKLE? | | ν | 56814 | | 11/15/ | 06 | | | | |
| | Q | | 30. Name and address of person who | completed cause of death (Ite | m 23a) (Type | Driet | | | - | | | | | |
| | 8 | | 31. Date filed (Month, Day, Year) | 15/1g 75950 | DSUr | DR.5 | INTE395 | Towsor | MDZI | 204 | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month Year **Physician** GERALDINE YEAGER D. HOV 21 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNION MEMORIAL HOSPITAC BALTIMORE CITY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 1 217-26-0461 Maryland 2 1930 Director Usual Residence of Decedent 10c. City, Town or Location the Maryland 10d. Inside City Limits 10a. State 10h County ns 23a or 28a-f show must be notified at XXYes 2 No MD N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. 21211 3620 Elm Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★★No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ¾ No Baltimore, Maryland 21215-0036 Specify Specify: white "natural", ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 7 is marked other than "natu traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk/ Claims Zurich Ins. Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Amos Carrie Vodusek ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If Item 27 is any Injury or other trat once. Richard Yeager (Son) 34 Mitchel Drive Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X⊠Burial 2 ☐Cremation 3 ☐Removal from State Maryland Veteran Cem. 11/27 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, 3631 Falls Road Baltimore, MD 21. Sign de le Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SERSIS **Physician** Weak disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DIVERTICUL ITTS 2 WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MYBLODYSPLASIA HYPERTENSION 25€No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Inpatient 2 ER/Outpatient 3 DOA Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No Medical Certification: To 28a. Date of Injury (Month, Day 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident Year) 5 Pending investigation ours after death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined within 24 hours a To the Funeral I **Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

31. Date filed (Month, Day, Year) NOV 8

29b. Signature and title of certifie,

33RD



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

29c. License number

Vinau

BALTIMORE

063369

29d. Date signed (Month, Day, Year)

2006

| | | | For State Registrar | | State of | Marylar | | artment of rtificate of | | | | giene Reg. No: | 11116 | 37639 |
|-----------|---|---------------------|---|------------------------------------|--|---------------------------------|----------------------------------|---|-----------------------------|---------------|---------------------------------------|--------------------------|---|--|
| ľ | Physici /Medic | | 1. Decedent's Name (First, M. JAMES FREDR | | | SR. | | | | | 2. Date of De Month | Day | 9, 200 | 3. Time of Death |
| | Examin | | 4a. Facility Name (If not instituted MANOKI N N | _ | e street and num | iber) | | 4b. City, Town, Prince | | | | | County of Dea | |
| ľ | Funeral Director | | 5. Social Security Number 219-34-4074 | | Sex V∏M 2∏F | 7. Age (In yrs. 87 | last birthday) Yrs. | If Under 1 Yea Months Days | | Min. 4 | B. Date of Bir / Month Da | 979 | 9. Bi Mai | rthplace (State or Foreign Jounty) Cyland |
| | show | ٥٢ | Usual Residence of Decedent 10a. State 10b. Cou MD Wore | inty | ter | | ty, Town or Lo | | | | | | | 10d. Inside City Limits 1 ☐ Yes 2☐No |
| | death with the Maryland ms 23e or 28a-f show rrival be rellited at | Direct | 10e. Street and Number 2422 McMaste | | | FOC | Omore | 10f. Zip Code 2185 | 1 | | | 10g. Citi | zen of What C | |
| 30 | 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "neturet", or Items 23e or 28a-f show tomatic event, the Medical Examinar must be relified at | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ N 3 ★ Widowed 4 □ Divor | Married | 12. Was Dece Armed For 1 Tyes If Yes, Giv Year or Da | ces? 2 X) No 9 | | Was Decedent of If Yes, specify Cu | Hispanic O ban, Mexica | an, Puerto Ri | ify Yes or No ican, etc.) | - | 14. Race - Am Black, Whi Specify: W | ite, etc. |
| 1213-UU30 | ithin 72 hou ne. hen "neture a Medical Es | Completed t | 15. Dece (Specify only hip Elementary/Secondary (0-1 | dent's E | ducation | | (Give | dent's Usual Occi kind of work don DO NOT use retir | e durina mo | st of working | | 16b. Ki | nd of Business | s/Industry |
| and 2 | oe filed w tal Hygier d other ti | 3e | 17. Father's Name (First, Mide | dle, Last, |) | | Farm | er | 18. Moth | her's Name (| First, Middle, | | icultu Sumame) | ıre |
| Maryla | should and Men s marke | To | Fredrick A. 19a. Informant's Name/Relati | ionship (| Type, Print) | _ | | ng Address (Stree | and Numl | | Route Numbe | | | |
| ē, | permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked eny injury or other treumatic es 2008. | | John S. Adar 20a. Method of Disposition | | | 1 , | Place of Dispo | MCMast esition (Name of matory or other pi | 1 | Rd.,] | | | City, | MD 21851 Town, State |
| Бащто | it. Pages rtment of rtent: If i njury or | | *A □ Donation 5 □ Othe 21. Signature of Funeral Serv | r (Specif | fy) | Red | noboth P. | resb, Cem. | - 1 | | /2006 | Re | hobeth | n, MD |
| 0 | Depar Impo eny ir | | Don't | AI | | | ! H | 2. Name and Add Olloway Fu | neral I | Home, Pa | | | | ian |
| | Physician /Medical | | 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) | i, or com List only | a | used the dear ach line. | ASCV | | ing, such a | s cardiac or | respiratory a | rrest, | | Approximate Interval Between Onset and Death |
| | Examiner | er | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | b | or as a consec | A | かし | | | | | | |
| Ď, | icate be executed physician and s the burial-transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | 1 | c. Due to (| or as a consec | quence of): | | | | | | | |
| 09/99 | tificate b ig physic as the bi | ledical | | | d | | | | | | | | | |
| O. Box | The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | | | nth 2 ☐ Feta antat time of o | al death 3 | Ectopic pregnan Other (specify) | | | | 2 | 23d. Date of de Month | olivery Day Year |
| cords, F | w requires that the de been signed by the s should be detached | ρ | Part II. Other significant con- | ditions | contributing to de | ath but not res | sulting in the u | nderlying cause g | ven in Part | : I. | 1 | obacco u Yes 2[| | o the cause of death? |
| r L | | Completed | | | | | | | | | 24a. Was autop perfo 1 🗆 Yes | | prior to death? | utopsy findings available completion of cause of |
| N II G | Physician: The this certilicate har all director, page | o Be | 25. Was case referred to med examiner? 1 Yes 2 No | lical | Hospital: | npatient 2□ |]ER/Outpatie | nt 3 DOA | thor / | | Check only o | | S □Other (Spe | 20.64 |
| on or | | - | 27. Manner of Death 1 ☑Natural 5 ☐ Pe | | 28a. Date o (Monti | · | 28b. Time o | f 28c. Inj | | 28 | ld. Describe h | | | нспу) |
| DIVISION | To the Hospitet or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the tuneral | Certification: | 3 ☐ Suicide 6 ☐ Co | estigatio uld not b termined | e 28e. Place | of Injury - At h | ome, farm, st. | reet, factory, office | | | f. Location (S City or Tow | Street and vn. State) | d Number or A | ural Route Number, |
| | e Hospit 24 hours 6 Funere etely fille | Medical (| 29a. Certifier 1 Certifier (Check only one) | ifying Ph cel Exa | nysicien: To the miner: On the ba and mann | sis of examina | owledge, deat ation and/or in | h occurred at the vestigation, in my | time, date a opinion, de | ind place, an | d due to the | cause(s) date and | and manner a place, and du | s stated. e to the cause(s) |
| | To th within To th compl | Me | 29b. Signature and title of cer | rtifier 1641 | / | | | | 709L | | | | e signed (Mon | |
| _ | BA 12 | | 30. Name and address of per- | son who | MATERA | -1 | 11.15 | Frint) | | Sheet | - 5/ | rusb | , wy | nd 21804 |
| | Sta Registr | | 31. Date filed (Month, Day, You NOV | | 2006 | gistrar's Sign | ature | book | | | | | | |
| 011 | 141147 0 4/0 | 204 | | | | | | | | | | | | |

DHMH 17 Rev 1/2001

| | | | _ State | State of Maryland | | irtment of Hi tificate of L | | | eg. No. | 37641 | | | |
|----------------------------|---|---------------|---|--|----------------------------|---|--------------------------------|---|--|--|--|--|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of Deat Month | | 3. Time of Death | | | |
| 41 | Physicia /Medic | | CLIFTON ANDER | SON BARBER | { | | | | R 10 2006 | 12:30 P M | | | |
| | Examin | er | 4a. Facility Name (If not institution, give s | | | 4b. City, Town, or MECHANIC | Location of Death | | 4c. County of Death ST. MARY S | | | | |
| | Funeral | | 28675 PATCH OF WO 5. Social Security Number 6. Sex | 7. Age (In yrs. la | st birthday) | If Under 1 Year | If Under 24 Hrs. Hours Min. | 8. Date of Birth | | hplace (State or Foreign | | | |
| П | Director | | 220-50-7136 | M 2□F 59 | Yrs. | Months Days | Hours Will. | | Month, Day, Year) JLY 30, 1947 MARYLAND | | | | |
| | and and | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, | Town or Lo | cation | | | | 10d. Inside City Limits | | | |
| | Mary | tor | MD ST. MARY | 's MECH | ANICS | VILLE | | | | 1 ☐ Yes 2x∏xNo | | | |
| | or 28 | Director | 10e. Street and Number | | | 10f. Zip Code | | 1 | 0g. Citizen of What Co | | | | |
| | s 23s | erail | 28675 PATCH OF WOOI | OS DRIVE 2. Was Decedent Ever in U.S | 13 \ | 20659 | spanic Origin? (Sp | ecify Yes or No- | U. S. A | | | | |
| 39 | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene, and Mental Hygiene, is marked other than "naturel; or items 23s or 28e-f show is marked other than "naturel; or items 23s or 28e-f show eumatic event, the Medical Examinat must be notified at | by Funeral | 11. Marital Status 1 □ Never Married ※ Married 3 □ Widowed 4 □ Divorced | Armed Forces? 15 Yes 2 □ No 17 Yes, Give Year or Dates: | | Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 🏋 No | n, Mexican, Puerto Specify: | Rican, etc.) | Black, Whit | e, etc. HITE | | | |
| O O | 72 hou | | 15. Decedent's Educ (Specify only highest grade | ing | 16b. Kind of Business | | | | | | | | |
| 2 | vithin ne. | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use retired |) | | EXCAVATING | | | | |
| 92 | filed v Hygie other t | 0 | 12 17. Father's Name (First, Middle, Last) | | HEAVI | EQUIPMEN | 18. Mother's Nam | | | | | | |
| lan. | Aental Aental rked c | To B | NINIAN PINKNEY BAR | BER JR. | | | GLADYS 3 | JANE AND | ERSON | | | | |
| Maryland 21215-0036 | 2 should and Men is marks | | 19a. Informant's Name/Relationship (Typ | | | | | | r, City or Town, State, | | | | |
| | ges 1 and 2 should to f Health and Men if item 27 is marke or other treumatic | | LINDA J. BARBER / | 20b. Pl | ace of Dispo | sition (Name of | | | HANICSVILL 20c. Location - City or | E MD 20659 Town, State | | | |
| nor | Pages nent of h snt: if its sry or of | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) | emoval from State | - | natory`or other plac | | | CHAPTICO, | MARYLAND | | | |
| Baltimore, | permit. Page Department of Important: If ony injury or once. | | 21. Signature of Funeral Service License | no cot | 22 | . Name and Addres | s of Facility BR | INSFIELD | | NL.HME.,P.A. | | | |
| | | | 23a. Part1. Enter the disease, or complishock, or heart failure. List only on | cations that caused the death | _ | | | | | Approximate Interval Between | | | |
| | Physician | | Immediate Cause (Final disease or condition | | long | Can. | ce | | | Onset and Death | | | |
| | /Medical Examiner | | resulting in death) | Due to (or as a consequ | ence of (| Kidney | Stom | | | | | | |
| | | Jer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequ | | A | 3 10.00 | | | | | | |
| | ficate be executed physicien and is the burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | | | nemin | | | | | | | |
| 60, | be exe | a Ex | issuming in additity cast | Due to (or as a consequ | erice or, | | | | | | | | |
| 68760, | ificate g phys as the | edicai | | | | | | | | | | | |
| Вох | that the death certii ed by the ettending detached for use a | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal | death 3 | Ectopic pregnancy | | | 23d. Date of de Month | livery Day Year | | | |
| P.O. E | he dea the el | ysici | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4∏Pregnant at time of de 9☐ Unknown | ath 5[| Other (specify) | | | | | | | |
| | law requires that the as been signed by th 2 should be detache | by Ph | Part II. Other significant conditions con | ntributing to death but not resu | Iting in the u | nderlying cause give | en in Part I. | 23e. Did to | bacco use contribute t | o the cause of death? | | | |
| rds | w requires been sig should by | ed b | | | | | | 1 □ Y | es 2□No 3□P | robably 4 Dunknown | | | |
| Division of Vital Records, | sician: The law re certificate has be irector, page 2 sho | Completed | | | | | | 24a. Was a autop perfor 1 Yes | sy prior to death? | utopsy findings available completion of cause of | | | |
| /ita | Physician: this certificantal director, it | Be | 25. Was case referred to medical examiner? | lospital: | | ot 3C DOA Oth | 26. Place of Dea | / | | | | | |
| of | Phy r this rald | 5 To | 1 ☐ Yes 2 ☑ No 27. Manner of Death | 28a. Date of Injury | ER/Outpatie 28b. Time o | f 28c. Injur | y at | | lence 6 Other (Spenow injury occurred | əcify) | | | |
| ion | Attending r death. ector: Atteby the fune | ation | 1 Matural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Year) | Injury | M 1 🗆 | k? Yes 2 □ No | | | | | | |
| Divis | al or Attends after deall I Director: | ertification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At ho building, etc. (Specify | me, farm, st | reet, factory, office | | 28f. Location (S City or Tow | Street and Number or F n, State) | lural Route Number, | | | |
| | To the Hospital or At within 24 hours after of To the Funerel Directompletely filled in by | ledicai C | | sinian: To the best of my knowner: On the basis of examinal and manner stated. | | | | | | | | | |
| | To the within 2 To the complet | Me | 29b. Signature and title of certifier | | | 29c. Licens | | | 29d. Date signed (Mon | • 1 | | | |
| | | | | 40 | | | 50290 | | 11-10 | - 06 | | | |
| ر د | 501B | \$ | 30. Name and address of person who co | 110 . 405 | P 1 | Print) | Poince | Foed | NID | 20678 | | | |
| | St. Regist | ate rar | 31. Date filed (Month, Day, Year) NOV 1 3 200 | Registrar's Signa | ture | WE ! | | | | | | | |

State of Maryland / Department of Health and Mental Hygienea For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Mae 9, 4:25 A Goldie November 2006 Burdette /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery General Hospital 01ney If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 9, 1922 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 ₹ F Months Days Hours Mary Land 577-26-4117 84 Yrs. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County If itam 27 is marked other then "naturel", or items 23s or 28s-1 show or other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Director Clarksburg Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20871 14209 Lewisdale Road U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Wo If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If itam 27 is marked other then "naturel", or its marked prior or other traumatic event, the Modical Exertine and once. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: þ White 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) U.S. College (1-4or 5+) Elementary/Secondary (0-12) Administrative Aide Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Maggie Allnutt Merson Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20871 John R. Burdette - Son 13009 Prices Distillery Road, Clarksburg, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriai 2 □ Cremation 3 □ Removal from State Mt. Olivet Cemetery 11/13/06 Frederick, Maryland 4 □ Denction 5 □ Other (Specify) 21. Signature of Fun ral Service Lices Molesworth-Williams P.A., Funeral Home overt o Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed signed by the ettending physicien and I be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown been si 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes s certificete has b lirector, page 2 s 1 Yes 2 or Attending Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes Certification: To npatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Matural 5 Pending death. 1 ☐ Yes 2 ☐ No I Director: A d in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funerel Direct 4 - Homicide entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cepitier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print)

Ludrew (8101 Princy Philip Drive Olvey MD 20832)

32. Proistrar's Signature State NOV 13 Registra

| | | For State Registrer | State o | of Marylan | | artment rtificate | | | and Me | - | giene | $\alpha \wedge \alpha$ | 6 3 | 376 | 143 |
|---|---------------|--|--|---------------------------------|------------------------------|----------------------|----------------------|-------------|-------------|--------------------------------|--------------|--------------------------------|-------------------------------|----------------------------|--|
| | | Decedent's Name (First, Middle | e, Last) | | | | | | | 2. Date of De | ath | | | 3. Time of | Death |
| Physicia | | Brenton | Ivv Ba | augher | | | | | | Month Novemb | er 8 | | 6 | 5:35 | АМ |
| /Medic Examin | | 4a. Facility Name (If not institution | | | | 4b. City, To | own, or l | _ocation of | f Death | | 40 | | | | |
| | Τ. | 10111 Moxley | Road | | | 1 | Dama | scus | | | | Mon | tgom | ery | |
| Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In yrs. | last birthday) | If Under 1 Months | Year Days | If Under 2 | 24 Hrs. | B. Date of Bir (Month, Da | th Vear | 9. | | ce (State o | or Foreign |
| Director | | 214-28-8862 | 1⊠M 2□F | 76_ | Yrs. | Wildington | Days | Tiours | | ct. 1, | 19 | | irgi | | |
| pu . | | Usuel Residence of Decedent 10a. State 10b. County | | 10c Cit | ty, Town or Lo | cation | | | | | | | 104 | J. Inside Ci | ity Limite |
| aryie sho | ក | | | 100.00 | _ | | | | | | | | 100 | 1 ☐ Yes | • |
| the N | Director | Maryland Mon 10e. Street and Number | tgomery | | שני | 10f. Zip C | | | | | 10a Cir | tizen of Wha | t Country | | |
| after deeth with the Maryler or Iteme 23a or 28a-f show | 급 | | D 1 | | | 101. 210 | | 0072 | | | | | | | |
| eeth | Funeral | 10111 Mox1ey | | edent Ever in U | S. 13. | Was Decede | | 0872 | nin? (Spec | ify Yes or No | | nited | | | |
| fler deer r iteme | Fun | 1 Never Married 2 ☑ Mar | Armed Fo | orces? | 1 | | | , Mexican, | , Puerto R | cify Yes or No lican, etc.) | | | White, etc | c. | |
| urs a | by | 3 Widowed 4 Divorced | If Yes, Gi Year or D | ve lates: | | 1 ☐ Yes 2 | X No | Specify: | | | | Specify: | Wh | ite | |
| be filed within 72 hours after deeth with the Maryland be filed within 72 hours after deeth with the Maryland of the filen of the filed from the notified at event, the Madical Examiner must be notified at | Completed | | it's Education st grade completed) | | | dent's Usual | | | of working | 0 | 16b. K | ind of Busin | ess/Indus | stry | |
| Mag | nple | Elementary/Secondary (0-12) | College (| 1-4or 5+) | life. | DO NOT use | retired) | ning most | Or WORKING | 9 | | | | | |
| be filed within 72 ho ital Hygiene. Id other then "natu | Co | 12 | | | N | lachin: | | | | | | J.S. G | over | nment | <u>: </u> |
| d al H | Be | 17. Father's Name (First, Middle, | | | | | | | | (First, Middle | , Maiden | Sumame) | | | |
| 2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the Mental Mental control of the Mental control of | ٦ | Charles W. Ba | | | | | | | | Snow | | | V 1 | | |
| d 2 should th and Mer 7 is marke treumatic | | 19a. Informant's Name/Relations | | | | | | | | Route Numb | | | | | |
| 1 and Health Fm 27 ther t | | Peggy Baugher 20a. Method of Disposition | / wire | 20b. F | Place of Dispo | Mox1e | | oaa | Dam | ascus, | | ocation - City | | | |
| permit. Pages 1 and 2 Depertment of Health a Importent: if Item 27 is eny Injury or other tre | | 1 ☑ Burial 2 ☐ Cremation | | State | cemetery, cres | matory or oth | er place | 1 1 | Novem | | | | | | |
| it. Partme | | 4 □ Donation 5 □ Other (S 21. Signature of Juneral Service | | Pi | ne Gro | | | | 11, 2 | | | Airy, | | | |
| permit. Departr Importe eny inju | | * Indel | 211/m | 1/ | | | | | | uffer . Mt. | | | | | |
| | | 23a, Part1. Enter the disease, o | complications that | caused the deat | | | | | | | | y, Ma | A | oproximate | 0 |
| D | | shock, or heart failure. List Immediate Cause (Final | only one sause on | each line. | | | | | | | | | | nterval Ben Inset and I | |
| Physician /Medical | | disease or condition resulting in death) | a | (or as a consec | | ailo | | | | | | | 4 | m, | 0 |
| Examiner | | | 300.0 | e y 6 | | 4-7 | 1 | / | KOK | - | - | | 1 | 54 | -5 |
| | Je | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to | (or as a consec | (uence of): | | | 0 70 | | | | | <u> </u> | | |
| outed nd ransit | Examiner | Cause (Diseese or injury that initiated events | S . | | | | | | | | | | | | |
| be executed sicien and burial-transit | | resulting in death) Last | Due to | (or as a conseq | (uence of): | | | | | | | | | | |
| sate be shysici the bu | dlcal | | d | | | | | | | | | | | | |
| ing pl | Med | IF FEMALE: | T | | | | | | | | | | | | |
| ath certific | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | 1 Live I | tcome of pregna pirth 2 Peta | Ideath 3 | Ectopic preg | | | | | | 23d. Date of Month | f delivery Da | | Year |
| by the e | /slc | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4⊟Prega | nant at time of o | death 5 | Other (spec | cify) | | | | | World | | -, | |
| The law requires that the death certification is the been signed by the ettending page 2 should be detached for use es | | Part II. Other significant conditi | ons contributing to d | eath but not res | sutting in the u | nderlying cau | ISA GIVA | in Part I | | 23e. Did t | obaccou | use contribu | te to the o | cause of d | leath? |
| signe d be | d by | Anime |) , (7 | | blec | | .50 g.ro. | | | 10 | | _ | | oly 4 □L | |
| w requir been si should | ete | | , , | | | | / | | | - | | 1 - 0 - 11 | | | |
| e law | Completed | 24a. Was an autopsy performed? | | | | | | | | | 24b. Wer | e autopsy r to compl th? | y findings a pletion of ca | available ause of | |
| | | | | | | | | | | 1 ☐ Yes | 2 N o | | Yes 2 | □ No | |
| sicie | o Be | 25. Was case referred to medica examiner? | Hospital: | | lenio : :: | | Other | | | (Check only o | | - 70 | | | |
| Phys | - | 1 ☐ Yes 2 € No 27. Manner of Death | 28a. Date | of Injury | ER/Outpatier 28b. Time of | | c. Injury : Work? | 4 🔲 INUI | | e Santesi d. Describe | | | Specity) | | |
| ding th. | 할 | Natural 5 ☐ Pendir 2 ☐ Accident investi | ng (Mon gation | nth, Day Year) | Injury | м | | es 2 □N | No | | · | | | | |
| Atter r dea ctor by th | E C | 3 ☐ Suicide 6 ☐ Could | nined 289. Place | of Injury - At h | ome, farm, str | reet, factory, | office | | 28 | Sf. Location (| | | r Rural R | Route Num | ber. |
| s efte | Certification | 4 Homicide | build | ing, etc. (Specil | (Y) | | | | | City or To | wn, State | 9) | | | |
| To the Hospitel or Attending Physicien: within 24 hours eller death To the Funerei Director: Atter this certifica completely filled in by the funeral director, | edical (| 29a. Certifier Certifyii | ng Physician: To the Examiner: On the b | e best of my kno | owledge, deat | h occurred at | the time | o, date and | d place, an | nd due to the | cause(s | and manne | or as state | ed. | |
| the hin 24 the F | Med | one) 29b. Signature and title of certifie | and man | ner stated. | | | License | | | | | te signed (N | | | |
| F 3 F 8 | | 250. Signature and title of contine | | | | | | | | | | | | | |
| 12×1/1/2 | | 30. Name and address of person | who completed a | sa of doot fit- | 7 7 | Print | 14 | 625 | - | Free | /\/ | 0 | 7) | 200 | 7 C |
| 10, | | O. Name and address of person | 2 de s | on water (itter | ., 23a) (1yp8, | Co. 1 G | 10 | 47 | 56 | Free | des | de | 10 | 200 | 201 |
| Sta | te | 31. Date filed (Month, Day, Year, | | Registrar's Signa | ature | has. V. | - 1 | | | , | (. / | | | 4// | 01 |
| Registr | | NOV 1 | 3 2006 | THE WAY | N. A | STORE STORES | E | | | | | | | | |

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Shirley James Brown November 5, 2006 11:40 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3701 International Drive, #415 Silver Spring Montgomery 5. Social Security Number 6. Sex if Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 1 X M 2 □ F 234-12-6721 90 July 25, 1916 West Virginia Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2√2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 3701 International Drive, #415 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify SpecifyWhite 2 If Yes, Give Year or Dates: WWII 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Brown Artie Suttle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ilene W. Brown/ wife 3701 International Drive, #415, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State November 9 Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2006 Rockville, Maryland 21. Signature of Funeral Service Licensee Francis of Add Collins Funeral Home Inc. Dep Imp any 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a Metastatic Non-Small Cell Lung Cancer disease or condition resulting in death) less_than_6 /Medical Due to (or as a consequence of): months Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner daath certificate be executed attanding physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signad by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 A Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an paga 2 s perform 1□ Yes 2 X No or Attending Physician: diractor. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funaral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation daath. 1 ☐ Yes 2 ☐ No 2 Accident tha f Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillad in by determined 4 Homicide within 24 hours a

To the Funeral I 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) d60335 November 9, 2006 Barros 10+1 1 au 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Bannen, M.D 18111 Prince Philip Drive, #327, Olney, MD 20832 31. Date filed (Month, Day, Year) 32. gistrar's Signature State 2006 Registrar

Division or Vital Records, P.O. Box 68760.

| | | For State Registrar | State | of Marylan | - | artmen rtificat | | | | jiene •g. No.2 (| 006 | 37645 |
|--|----------------|--|---|--|---|-----------------------------|--|---|---|--------------------------|------------------------------------|--|
| Physici | | Decedent's Name (First, Middle John Joseph Bay | | | | | | | 2. Date of Dea Month November | Day | Year 6 | 3. Time of Death 4:55 ^{a M} |
| /Medi Examir | | 4a. Facility Name (If not institution | , give street and n | umber) | | 4b. City, | Town, or | Location of Death | | 1 | ty of Death | |
| Funeral Director | | Shady Grove Advent 5. Social Security Number 231-18-7367 | ist Hospita 6.Sex 1≧M 2□F | 7. Age (<i>in yrs.</i> 82 | last birthday) Yrs. | If Under Months | Rockv 1 Year Days | rille If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day March 24 | Year) | 9. Birthp Coun | lace (State or Foreign http:// |
| <u>D</u> | , | Usual Residence of Decedent 10a. State 10b. County District of | | 10c. City | y, Town or Lo | cation | 1 | | | | 1 | 0d. Inside City Limits 1 ☑ Yes 2 ☐ No |
| ith the M or 28a-f | Director | Columbia - 10e. Street and Number | | | Wash | ington 10f. Zip | | | 1 | Og. Citizen o | f What Coun | |
| be filed within 72 hours after death with the Maryland tial Hygiene. Is do than than "natural", or items 23a or 28a-f show avent, the Medical Extrainer must be notified a | Funeral | 5420 Connecticut 11. Marital Slatus 12 Never Married 2 Marr | 12. Was De Armed F ied 1 (2) Yes | cedent Ever in U. Forces? 2 No Sive | | Was Deced | rfy Cubar | spanic Origin? (Son, Mexican, Puerto | pecify Yes or No- o Rican, etc.) | Bt | USA ace - Americ ack, White, | |
| d within 72 hours af giene. ir than "natural", or itte Medical Expin | Completed by | 3 Widowed 4 Divorced 15. Deceden (Specify only higher Elementary/Secondary (0-12) | 's Education it grade completed College | Dates: 1943-4 (1) (1-4or 5+) | 16a. Deced (Give life. | kind of wo DO NOT us | rk done d se retired; | uring most of wor | king | 16b. Kind of | Business/Ind | |
| filed Hygi other | 0 | 17. Father's Name (First, Middle, John Wesley Bay | | | A | ccount | | | ne (First, Middle, | | | gement |
| d 2 should be th and Menta ?7 Is marked traumatic av | _ | 19a. Informant's Name/Relations | nip (Type, Print) | | | arres acce | 0.02000 | nd Number or Ru | ral Route Number | r, City or Tow | | Code) |
| of Heal | | 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S | 3 □Removal from | n State | 3400 Mn lace of Dispo emetery, crer copolita | sition (Nar. matory or o | ne of ther place | Novem | iber 9, | DC 2001 20c. Location | - City or To | |
| permit. Page Depertment of Important: if any injury or once. | | 21. Signature of Funeral Service | lus Mato | yh | .50 | 0 Univ | ersit | s of Facility llins Fune y Blvd, W, | eral Home l Silver Sp | inc. oring, M | -7.0-2 | |
| Physician /Medical Examiner but site of the private | dical Examiner | 23a. Part Enter the disease, or shock, witheart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. 1 a.y., leading to min adiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a | each line. | EPS (uence of): PNE(| 15 | | | | | | Approximate Interval Between Onset and Death |
| ath certii ittending or use a | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 1 Live | utcome of pregna birth 2 Fetal gnant al lime of de nown | death 3 | Ectopic pr | | | ar emin t | | Pale of delive | ory Day Year |
| quires that the de in signed by the e uid be detached f | by | Part II. Other significant condition | ons contributing to | death bul nol resi | ulling in the u | nderlying c | ause give | n in Part I. | | bacco use co | | ne cause of death? ably 4 Unknown |
| sician: The law requires t certificete has been signe rector, page 2 should be o | Completed | | | | | | | | 24a. Was a autops perfor | SV | prior to cor death? | psy findings available inpletion of cause of |
| ding Phys h. After this funeral di | ation: To Be | 25. Was case referred to medica examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir investi | g 28a. Dat (Mo | Inpatient 2 e of Injury onth, Day Year) | ER/Outpatien 28b. Time of Injury | | 8c. Injury Work | al Nursing H | th (Check only or ome 5 - Resid 28d. Describe h | ence 6 🗆 O | | <i>(</i>) |
| To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | Certification: | 3 Suicide 6 Could 4 Homicide determ | ined 286. Place | ce of Injury - At ho ding, etc. (Specify | v) | | | | City or Tow | n, State) | | l Route Number, |
| the Hosp hin 24 hou the Funel apletely fil | Medical | (Check only 2 Medical one) | | ne best of my kno basis of examina inner stated. | wledge, death tion and/or in | vestigation | at the tim , in my op :. License | inion, death occu | rred at the time, d | late and place | a, and due to | the cause(s) |
| 6+1 | | 29b. Signalure and title of certifie | Lu | • | - lle | > | | 057/2 | | 9d. Date sign | 8/D | |
| τ. | | 30. Name and address of person Truong Bao, M.D | | , | | - | antow | n, MD 2087 | 4 | | | |
| Sta . Regist | ate rar | 31. Date filed (Month, Day, Year) | | Registrar's Signa | | - | *4 | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month ERKOWITZ 5150 AM 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTROSE HEBREW HOME - 6105 KOCKVILLE, MD MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 1, 1916 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country)
 Poland Months 081-10-2096 Yrs. Director 90 Usual Residence of Decedent 10a. State 10b. County permit. Pages 1 and 2 should be liled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "neturel', or Items 23e or 28a-f show any injury or other treumatic event, Ira Modical Extrainer must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Maryland | Montgomery Director Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9407 Curran Road 20901 Funerai United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 Ñ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced white Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Several Businesses 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Kutchinsky 2 Rae Yachobuvich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francine Berkowitz, Daughter 9407 Curran Road, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 11/13706 1X Burial 2 ☐ Cremation 3 X Removal from State King David Memorial Garden 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA 21. Signature of Furnat Service Licenses Torchinsky Hebrew Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. NW, Washington, DC tmmediate Cause (Final disease or condition resulting in death) Physician for ovonary /Medical Due to (or as a con Juence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant al time of death P.O. Month 5 Other (specify) 9 Unknown þ been signed be should be deta Part II. Other significant complitions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 21 No 3 Probably 4 Unknown 1 ☐ Yes Pustipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed antohomen 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) : After t Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation Injury within 24 hours after death.

To the Funerel Director: A completely filled in by the fu death. 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicet Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060170 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6105 Montrose Road, Rockville. MD 20852 Ghazinouri Grea Washin

State Registrar 31. Date filed (Month, Day, Year)

NOV

Bekoui

| The attended the completion | Ellowie I III ooploo Ale Legit |
|-------------------------------------|--------------------------------|
| State of Maryland / Department of H | ealth and Mental Hygiene |

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Georgina J. Bezos aM November 9, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F Yrs. 578-72-7065 Director 91 16, 1915 Cuba Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show Examiner must be notified at 1 Yes 2 No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 2409 Evans Drive 20902 Cuba Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑★o If Yes, Give Year or Dates: 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 □xYes 2□ No Specify: Cuban Specify: White ğ 3- Widowed 4 □ Divorced netural Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent. If tem 27 is marked oth any injury or other treumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pedro Hernandez Juana Mateu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angel P. Bezos/ son #5 Fairwood Court, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State November 13 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 2006 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis Collins Funeral Home Inc. Sheer 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) isolumic sowel disease **Physician** 6 days /Medical Due to (or as a consequence of): Examiner Diasits Melitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detected for use as the burial-transit Chrinic Manal Jalline Due to (or as a consequence of): martin Myo choice Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Anemia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case relerred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To ot 28a. Date of Injury (Month, Day Year) 0 00 00 Division o 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 29256 Noumber 9, Zuol 75056 A. GVINIS MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. QUINUS MI.D. 4343 MontgoMery Ave., Bethesda, MD 20814 JUSE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 NOV 13 Registrar

620

State of Maryland / Department of Health and Mental Hygiene 2006 1 - Stata Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 4 2006 **Physician** 0245 Gladys Bush /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | Government | G Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 👿 F 040-36-5000 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Itema 23a or 28a-f show the Madical Examinar must be notified at 1 V Yes 2 No Director Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21403 USA 1416 Chesapeake Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Engineer General Electric 12th 3yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fitted Department of Health and Mental Hy Important: If Item 27 is marked oth any njury or other traumatic event space. Be Elizabeth Cooke Joseph Catchings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William L. W. Bush(Husband) 1416 Chesapeake Ave Annapolis, Md. 21403 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11-7-06 Baltimore, Md. Metro Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. Larry D. Keese MO0483 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acale Gespiralory
Due to (or as a consequence of): Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner led by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Pulmonar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ been signe should be 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has this certificate 1 Yes 2 🔀 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After t Attending 5 Pending investigation 1 SNatural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) completely filled in by 4 ☐ Homicide 5 Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1447494 11/4/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONIQUE CANCETON, P.O. 1414 FORSHT PR. 31. Date liled (Mon (QV "gar)8 2006 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygienes 37649 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician November 2,2006 4:40pm M Elayne D. Blackman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Nursing Home Prince Georges Largo If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 ☐ M 2 🖾 F 82 1924 Washington, Director 578-32-1122 June 20. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other then "natural" --- any injury or other freumatic events. 10c. City, Town or Location 10d. fnside City Limits 10a. State 10b. County Maryland Prince Georges Forestville 1X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2100 Brooks Drive 20747 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Year or Dates: ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) Colfege (1-4or 5+) 12 Editor Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Plummer Hulda Jeter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dannette Lawrence/Daughter 2400 Queens Chapel Rd., #720, Hyattsville, Md. 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 10, 2006 Lincoln Memorial Cem. Nov. Suitland, Md. 4 Donation 5 Other (Specify) Pope Funeral Homes 5538 Marlboro Pike 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility MOLUSS 20747 Forestville, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DIABETES MELLITUS **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 🗌 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 21 No 25. Was case referred to medical 26. Pface of Death (Check only one) examiner? Other: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral d 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 Yes 2 No investigation 2 Accident filled in by the Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Direct 29a. Certifier 1KI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 58/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donald George, M.D. 7525 Greenway Center Way, Suite 113; Greenbelt, Md. 20770 1 3 2006 31. Date filed 32. Registrar's Signature State Registrar

| | | | 1 - For State Registrar | State of | Maryland | d / Depa <i>Cel</i> | artmen rtificat | t of H | ealth a Death | and M | | iene2 (| 006 | 37650 |
|----------------------------|---|------------------|--|--|--------------------------|------------------------|--------------------------|--------------------|---------------------|-----------------|---|--------------|-------------------------|--|
| | | | 1. Decedent's Name (First, Middle, | Last) | | | | | | | 2. Date of Deat Month | | V | 3. Time of Death |
| | Physici /Medic | | Lelian P. Ba | ptiste | | | | | | | Novembe | | Year 2006 | 6:10a M |
| | Examin | | 4a. Facility Name (If not institution, g | ive street and num | ber) | | 4b. City, | Town, or | Location of | | | | nty of Death | |
| | | | Clinton Nursing | | . Cente | er | | nton | | | | Pr | ince G | eorge |
| | Funeral Director | | 214-96-8923 | . Sex 1 □ M 2 🛣 F | 7. Age (In yrs. Ia 65 | ast birthday) Yrs. | If Under Months | | If Under Hours | 24 Hrs. Min. | 8. Date of Birth (Month, Day, 6/15/19 | Vear) | Cour | place (State or Foreign http) ILDAD |
| | and w | | Usuel Residence of Decedent 10a. State 10b. County | | 10c, City | , Town or Lo | cation | | | | | | | 0d. Inside City Limits |
| | Manyl f eho | ō | MD PRINCE | CEODOE | LANI | | | | | | | | ' | 1X Yes 2 □ No |
| | 28a | Funeral Director | 10e. Street and Number | GEURGE | LIAM | ITAPI | 10f. Zip | Code | | | 1 | On Citizen | of What Cour | |
| | 3a or | | 6880 RIVERDALE R | OAD #833 | | | 207 | | | | | • | or 111741 0041 | y. |
| | me 2 | Jera | 11. Marital Status | 12. Was Dece | dent Ever in U.S | S. 13. | Was Deced | dent of His | spanic Ori | gin? (Spe | ocify Yes or No- | USA 14. F | Race - Americ | can Indian, |
| 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-1 show any injury or other traumatic event, The Medical Examinat must be notified at ODGS. | þ | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed For 1 ☐ Yes If Yes, Give Year or Da | 2 📉 No 9 | | f Yes, spec 1 ☐ Yes | | Specify: | i, Puerto I | Rican, etc.) | | Black, White, cify: IND | |
| Ö N | 72 ho | Completed | 15. Decedent's (Specify only highest of | Education | | 16a. Dece | dent's Usua | al Occupa | ition | * = f= dei- | | 16b. Kind of | Business/In | dustry |
| 2 | thin is | nple | Elementary/Secondary (0-12) | College (1- | 4or 5+) | life. | kind of woi DO NOT us | se retired) | u <i>ring mo</i> si | t ot workir | ng | | | |
| 2 | ygien ygien t, h | Con | 1 | | | HOUSE | KEEPE | ER | | | | DOMES' | TIC | |
| <u>n</u> | tal H d ott | Be | 17. Father's Name (First, Middle, La | • | | | | | | | (First, Middle, M | Maiden Sum | ame) | |
| Maryland | a Mer narke | P | DANIEL DAVID | | | | | | IV | | | OOLAR | | |
| Ma | 12 sh h and 7 le m traum | 7 4 | 19a. Informant's Name/Relationship | | - | | | | | | l Route Number, | | | , |
| e, | 1 and Heelt em 2 ther | 1 | FRANCIS BAPTISTE 20a. Method of Disposition | - HUSBAI | | 6880 ace of Dispo | | | ROA | | PT.#833 | | M,MD 2 | |
| ٥ | nt of nt of t: If it | | 1 Burial 2X Cremation 3 | | tate ce | metery, crer | natory or o | ther place | 1 | | | | | |
| altimore, | nit. Pa entme ortani injury | | 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Fynegal Service Lic | | fr.1 | LINCOL | N CRE | MATO | RY . | 11/14 FT | 1/2006 B LINCOL | RENTWO | 00D, M | ARYLAND |
| Ba | Dep impo | | 1 Clab | Milk | 1 | | | | | | | | | |
| | | | 23a. Part1. Enter the disease, or co | mplications that ca | used the death. | . Do not ent | er the mod | e of dvino | such as | cardiac o | DAD., BR | et | | |
| | Physician | | Immediate Cause (Final | ly one cause on ea | End (+ | / | Line | 111 | Phila | hu | Pulmos | . a. A | | Approximate Interval Between Onset and Death |
| | /Medical | | disease or condition resulting in death) | a. Due to (c | or as a conseque | edce of): | | -1 6 6 | 744770 | corre | 1 101 | 17thy Di | flise | |
| Ь | Examiner | | | , | | J | | | | | | | | |
| Ц | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (c | or as a conseque | ence of): | | | | | | | | |
| | cuted | Examiner | Cause (Disease or injury that initiated events | c | | | | | | | | | | |
| Ó | e exe ien a urial-l | EX | resulting in death) Last | Due to (d | or as a conseque | ence of): | | | | | | | | |
| 58760, | icate be executed physicien and s the burial-transit | dicai | | d | | | | | | | | | | |
| _ | | a 1 | IF FEMALE: | | | | | | | | | | | |
| P.O. Box | ath c | Physician/M | 23b. Was decedent pregnant in the past 12 months? | | th 2 Fetal | death 3 | Ectopic pr | | | | | | Date of delive Month | ory Day Year |
| o | the c | ysic | 1 ☐ Yes 2 ☐No 9 ☐ Unknown | 4∐ Pregna 9□ Unkno | int at time of dea wn | ath 5∟ | Other (sp. | ecity) | | | | | | ouy rour |
| _ | thet t ed by detax | 4 P | Part II. Other significant conditions | contributing to dea | ath but not resul | Iting in the u | nderlying c | ausa diva | n in Part I | | 23e. Did tob | acco use co | ontribute to th | e cause of death? |
| Division of Vital Records, | The law requires that the death certif ste hes been signed by the ettending page 2 should be detached for use a | d by | | • | | | | gc | | | 1 □ Ye | | | ably 4 Unknown |
| Ö | w req beer shou | Completed | | | | | | | | | 24a. Was ar | | | |
| Re | The lav | m d | | | | | | | | | autopsy perform | / | prior to cor death? | psy findings available apletion of cause of |
| æ | | ပိ | 25. Was case referred to medical | | | | | | | | 1 Yes 2 | □ No | 1 ☐ Yes | 2 No |
| > | s cert | 0 8 | examiner? | Hospital: | patient 2 E | D/Outpation | . a 🗆 Do | | | | Check only one | | | |
| ō | Attending Physician: r death. ector: After this certific by the funeral director. | P- + | 27. Manner of Death | 28a. Date of | | 28b. Time of | | 8c. Injury Work | at 4/20(Nu | | ne 5 Reside | | | ′) |
| 0 | ath. r: Aft | atio | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat | | i, Day Year) | Injury | М | | ? 'es 2 □ l | No | | | | |
| Vis | er death | il lie | 3 Suicide 6 Could not | ad 286. Place | of Injury - At hon | me, farm, str | eet, factory | , office | | 2 | 8f. Location (Str | eet and Nur | mber or Rura | l Route Number, |
| ā | rs efter el Dire | Certification: | | Duildiri | g, etc. (Specify) | , | | | | | City or Town | , Jiaie) | | |
| | To the Hospital or Attent within 24 hours effer deatl To the Funerel Director: Sompletely filled in by the | | (Olycer of the Selection of the Selectio | Physician: To the laminer: On the ba | sis of examination | vledge, death | occurred a | at the time | e, date and | d place, a | indidue to the ca | use(s) and | manner as st | ated. |
| | the thin 2 the mplet | Medicai | one) 29b. Signature and title of depthis | and mann | er stated. | | | | | | | | | |
| | F M F M | | Dog digital of and little of years and | | | | | License | | | | | ned (Month, I | |
| , | 0 (1) | | 20.4/ | ~ | MO | | | 0055 | 120 | | | IWV ! | 0 200 | 7 |
| 0 | KO | | 30 Name and address of person who when a support of the support of | o completed cause | of death (Item: | 23a) (Type, | Print) | sui! | te 310 |) W. | rhing hon | DC 2 | 2003) | |
| | Sta | te | 31. Date filed (Month, Day, Year) | 22. Re | gistrar's Signatu | | | | | | 1,001 | | | |
| | Registr | | NOV 1 3 200 | 10 hand | . A. | boer | | | | | | | | |

| | | | For State | State of Ma | aryland | | | | and M | ental Hy | giene |) | |
|---------------------|--|----------------|--|---|------------------------|-----------------------|--------------------------------------|---------------------------------|------------|------------------------------------|-----------------------|--|--|
| | | | Registrar | | | Cer | tificate of | Death | | | Reg. No. | 2006 | 3765 |
| | Physic | | Decedent's Name (First, Middle, La | , | | | | | } | 2. Date of Dea Month | Day | / Year | 3. Time of Death |
| | /Medi | cal | | Barrett | | | | | | Novembe | er 1 | 1, 2006 | 7:29 a ^M |
|) | Exami | ner | 4a. Facility Name (If not institution, give 6711 Cipriano Roa | | | | 4b. City, Town, | or Location o | of Death | | | County of Death | |
| ٠ | Funeral | | 5. Social Security Number 6. 8 | | (In vrs. la | ast birthday) | Lanham If Under 1 Yea | r If Under 2 | 24 Hrs. T | 8. Date of Birt | | ince Geo | |
| Ŀ | Director | 1 | 215-14-7586 | M 2□F | 91 | Yrs. | Months Days | | Min. | (Month, Day Dec. 25 | , Year) | 000 | place (State or Foreign intry) y land |
| | pu > | | Usual Residence of Decedent | | | | | | | DCC. 23 | , 1) | 14 Hai | yland |
| | aryla shov | ٦ | 10a. State 10b. County | | 10c. City, | , Town or Loc | cation | | | | | | 10d. Inside City Limits |
| | the N 28a-f | Directo | Maryland Prince G | eorge's | Lanh | am | · | | | | | | 1X Yes 2 No |
| | with a or t be r | | 6711 Cipriano Roa | a | | | 10f. Zip Code | | | | | zen of What Cou | ntry? |
| | ms 2: | Funeral | 11. Marital Status | 12. Was Decedent E | ver in U.S | 3 13 V | 20706 | Hienania Oria | sin2 /Con | | U.S | | |
| 9 | after or ite | 교 | 1 ☐ Never Married 2 X Married | Armed Forces? 1 ☐ Yes 2 ☑ No | | Jf | Vas Decedent of Yes, specify Cu | | , Puerto F | Rican, etc.) | | Race - Ameri Black, White, | can Indian, etc. |
| 8 | ours rai", Exar | d by | 3 Widowed 4 Divorced | If Yes, Give Year or Dates: | | 1 | ☐ Yes 21X No | Specify: | | | | Specify: Wh | ite |
| 2 | be filed within 72 hours after death with the Maryland nat Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at | Completed | 15. Decedent's Ed (Specify only highest gra | fucation ade completed) | | 16a. Deced | ent's Usual Occu | pation | of workin | a 1 | 16b. Kir | nd of Business/In | |
| 2 | withir ene. than | a u | Elementary/Secondary (0-12) | College (1-4or 5+ | -) | | rind of work done O NOT use retire | | OI WOIKIII | | | ffith | |
| d 2 | filed Hygid ther | ပ္တိ | 17. Father's Name (First, Middle, Last, | | | lank 1 | Truck Dr | | J. 81 | | | gy Serv | ices |
| an | should be filed of Mental Hygin marked other matic event, the | To Be | William T. Barret | | | | | 1 | | (First, Middle, l izabeth | | | |
| Maryland 21215-0036 | 0, = | - | 19a. Informant's Name/Relationship (| Type. Print) | | 19b. Mailine | Address (Stree | | | | | Town, State, Zip | |
| Ξ | Cd ' 'G | | Alice Barrett - W: | | | | Ciprian | | | | | r I own, State, 215 1 and 20 | |
| ore | of He of He fitem | | 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ | 5 | 20b. Pla | | ition (Name of atory or other pla | | Da | | | cation - City or To | |
| Ĕ | Pag ment ant: I | | 4 □ Donation 5 □ Other (Specify | Hemoval from State () | 1 | | oln Ceme | | 1/14 | /2006 | Brer | twood | Maryland |
| Baltimore, | permit. Pages 1 and Department of Health Important: If Item 27 any injury or other to | | 21. Signature of Funeral Service Licer | see / | | 22. | Name and Addre | ess of Facility | Gaso | h's Fu | nera | 1 Home, | P.A. |
| _ | 0 D = @ O | | THEUT CI, | lay | | | 4739 Ba | ltimore | e Ave | enue, H | yatt | | MD 20781 |
| | | | 23a Pa 1. Enter the disease, or com sh, ck, or heart failure. List only | licat s s that caused the cause on each line | he death. | Do not enter | the mode of dyi | ng, such as c | ardiac or | respiratory arre | est, | | Approximate Interval Between |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a Gastric | | | | | | | | | Onset and Death 6 Months |
| | Examiner | | () | Due to (or as a | conseque | nce of): | | | | | | | |
| 5. | | ē | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. — Due to (or as a | conseque | nce of): | | | | | | | |
| | cuted id ansit | Examiner | cause. Enter Underlying Cause (Disease or Injury that initiated events | | | , | | | | | | | |
| Ž, | e exerian ar | | resulting in death) Last | Due to (or as a | conseque | nce of): | | | | | | | |
| 00/00 | ficate be executed if physician and is the burlat-transit | edical | | d | | | | | | | | | |
| Ď X | ding p | Med | IF FEMALE: | | | | | | | | | | |
| Š | Verborisor or Attending Physician: The law requires that the death certificate be executed the bours after death. Funeral Director: After this certificate has been signed by the ettending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/M | in the past 12 months? | 23c. If yes, outcome pf 1☐Live birth 2 | Fetal d | eath 3□E | ctopic pregnanc | y | | | 23 | d. Date of delive | , |
| į | the d | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Pregnant at tir 9□Unknown | me of dea | th 5□(| Other (specify) | | | | | Month | Day Year |
| _ | s that ned by deta | | Part II. Other significant conditions co | ntributing to death but | not resulti | ng in the und | erlying cause giv | en in Part I. | | 23e. Did toh | acco use | e contribute to th | e cause of death? |
| ol day | quires | d by | | | | | , , | | | | | | ably 4 Unknown |
| ָ כ | aw requir s been si 2 should | Completed | | | | | | | _ | 24a. Was an | | | |
| | The I | E | | - | | | | | | autopsy perform | / | prior to con death? | osy findings available apletion of cause of |
| 2 | ctor, p | Be C | 25. Was case referred to medical | | | | | 26 Place of | f Doath // | 1□ Yes 2 Check only one | No | 1 □ Yes | 2 □ No |
| > | Physician: The law this certificate has trail director, page 2 s | 0 | examiner? 1 ☐ Yes 2 📉 No | Hospital: 1 Inpatient | 2 🗆 ER | ?/Outpatient | 3□ DOA Oth | 0.51 | | | | ☐Other (Specify | 4 |
| | Ing P | | 27. Manner of Death 1 X Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Y | 'ear) 28 | 8b. Time of Injury | 28c. Injur Worl | | | d. Describe how | | | / |
| | ttend leath ttor: / the f | cati | 2 Accident investigation 3 Suicide 6 Could not be | | | | M 1□ | Yes 2∐No | , | | | | |
| | affer of A | Certification: | 4 ☐ Homicide determined | 28e. Place of injury building, etc. (| - At home 'Specify) | e, farm, stree | t, factory, office | | 28f | Location (Street) City or Town, | et and l State) | Number or Rural | Route Number, |
| | I of the Nospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di | | 29a. Certifier 1 Certifying Phy | sician: To the best of r | my knowle | odgo doath o | Course d et the ti | | | | | | |
| : | e Ho le Fu | Medical | (Check only 2 Medical Exami | sician: To the best of ner: On the basis of example and manner stated | camination | n and/or inves | stigation, in my o | ne, date and p pinion, death | occurred | due to the car at the time, da | use(s) ar te and p | nd manner as sta lace, and due to | ited. the cause(s) |
| | withir comp | Me | 29b. Signature and title of certifier | | | | 29c. License | number | | 29 | d. Date s | signed (Month, D | Pav Year) |
| | | | · Varis | Man | 70 | 000 | 1 | 17 | 5 > | | | 1,100 | |
| 1 | (1) | | 30. Name and address of person who co | empleted cause of death | h (Item 23 | Ba) (Type, Pri | nt) | | | | | | |
| | | | David Gra | wite, ou | 0 1 | 150 | enter | way | 6 | reel | 160 | It out | 20770 |
| | Stat Registra | | 31. Date filed (Month, Day, Year) NOV 1 3 2006 | 32. Registrar's | Signature | 9 | | , | | | | | |
| | | | | Allegan D | . / | STATE | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Douglas Belcher, Sr. , 2006 /Medical November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Win. | July 5, 1925 5. Social Security Number 9. Birthplace (State or Foreign 1 XM 2 □ F 81 Kentucky 579-28-8175 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Prince George's Upper Marlboro Maryland Director Y□Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 204 Harry S. Truman Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No **Black** Specify. ş 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Psychiatric Nurse Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gracie Hubbard Will Belcher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Harry S. Truman Dr. Upper Marlboro, MD 20774 Donna L. Thomas - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ★Burial 2 Cremation 3 Removal from State Nov. 16, 2006 Landover, Maryland Harmony Mem. Park 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Furieral Service Lin 4001 Benning Road, NE Washington, DC 20019 23a. Part t Soter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Rupture of: of abdominal aortic Se pentially list confidential any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Dav 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Ves 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ EXOutpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 U certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, physician the asn page 2 this funeral after death Director: filled in by 24 hours a Euneral I

Funeral

Director

r 28a-f show notified at

ural", or Items 23a or Examiner must be

event, the Medical

21215-0036

Maryland

Baltimore,

1 and 2 should be Health and Mental

Pages 1

9

it if item

permit. Page Department of Important: If any Injury or once.

Physician /Medical Examiner

To the Hosp within 24 hor To the Fune completely f State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

039850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4850 Forbes Blad Lanhon, Mrd 20106 George C. Hajjor, John.D.

NOV 1 4 2006 Registrar

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

3001 HOSPITAL

CHEVERLY MD 20185

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

GEORGE

DONALD

NOV 1 4 2006

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Dav Year **Physician** November 8 Carrie W. Benefield 2006 04:45a /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🕏 F Feb. 19. 1925 Virginia Director 230-30-9764 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 28a-f show the Medical Exeminer must be notified at 1 Yes 2 No Washington Director D.C. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number or Items 23a 20018 USA 3521 28th Street, N.E. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married **Black** Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 X Widowed 4 ☐ Divorced naturel'. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Medical Receptionist marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be fand Mental I Maria Amiger Walter J. Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other treum once. 3252 Banneker Dr., N.E., Washington, DC Karen Benefield - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Arlington Nat. Cem. 11/21/2006 Arlington, V.A. 22. Name and Address of Facility
Fort Lincoln Funeral Home, 3401 Bladensburg Rd. 21. Signature of Funeral Service Licensee Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 Days **Physician** Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): Examiner Sequential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of) Box 68760 Physician/Medicai the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year ò 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a Ö 9 Unknown 9 Unknown ٥. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s rmed? 2⊠No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 4 THomicide within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier = D37891 November 8, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Rajvansur, M.D. 121 Congressional Lane, #409, Rockville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 4 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene ? 1 15 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1815 LOVEMBER 8 2000 Nancy Jean Bryant /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** DORCHESTER GENERAL HOSPITAL CAMBRIDGE DORCHESTER If Under 1 Year | II Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2X F Vrs 220-80-2763 45 Director Sept. 9,1961 Virginia Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show r than "natural", or iteme 23s or 28s-1 eho 1 ☐ Yes 2 No Dorchester Cambridge **Funeral Directon** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2615 Brian Circle 21613 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) child care 12 davcare worker other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental George Arthur Bryant Lois Wilson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2615 Brian Circle, Cambridge, MD 21613 Harold Alexander husband Item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Importent: If Its any Injury or of once. 5 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park | 11/11/06 Cambridge, MD 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 21613 Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Primaz Verticulna **Physician** /Medical nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No. 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2□ No 1 ☐ Yes 1 Yes or Attending Physician: 25. Was case relerred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 28a. Date of Injury (Month, Day Year) 28d, Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director; completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide describing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the nauro(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2006 address of person who completed cause of death (Item 23a) (Type, Print) Hurlock 302 31. Date filed (Month, Trar's Signature State Registrar

| | | | 1 - For State Registrar | State of Mary | | artment of F | | - | giene Reg. No 20 (| 06 37656 |
|------------------------------|---|----------------|---|---|-------------------------------|---|--------------------------------------|---|---------------------------------|--|
| | Physici | 20 | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of De. | | 3. Time of Death Year |
| | /Medic | _ | Dorothy Cordre | | | | | Novemb | | 006 8:15 p. M |
| 7 | Examir | ner | 4a. Facility Name (If not institution, give s Atria Assisted | | | 4b. City, Town, o | | ath | 4c. County o | COMICO |
| | Funeral | | 5. Social Security Number 6. Sex | | yrs. last birthday) | If Under 1 Year | If Under 24 H | rs. 8. Date of Birt | | Birthplace (State or Foreign Country) |
| | Director | | 220-01 - 9987 | M 2□X 9 | 1 Yrs. | Months Days | Hours Mi | n. (Month, Da Dec. 2 | | Delaware |
| 2 | ≥ (\$0) | | Usual Residence of Decedent 10a. State 10b. County | 100 | c. City, Town or Lo | cation | | | | 10d. Inside City Limits |
| Aaryla | e ho | ō | MD Wicomic | | or only, rount or Ec | | sbury | | | 1X Yes 2 □ No |
| 7 | 28a- | Director | 10e. Street and Number | 1 | | 10f. Zip Code | | | 10g. Citizen of Wi | hat Country? |
| death with the | 13a Ol | | 1110 Healthway D | rive | | | 21804 | | USA | |
| | ems 3 | Funerai | 11. Marital Status | 2. Was Decedent Ever Armed Forces? | in U.S. 13. | Was Decedent of H | lispanic Origin? an. Mexican. Pue | (Specify Yes or No erto Rican, etc.) | - 14. Race Black | - American Indian, , White, etc. |
| 2-0030 | or it | by Fu | 1 Never Married 2 Married 3 ∑Widowed 4 Divorced | 1 ☐ Yes 2 🔀 No If Yes, Give | | 1 ☐ Yes 2 🖾 No | Specify: | , , | Specify: | |
| 3-0030 72 hours af | iturai sal Ex | | 15. Decedent's Educ | Year or Dates: | 16a Dece | dent's Usual Occup | pation | | 16b. Kind of Bus | |
| Vithio 72 | Medic | Completed | (Specify only highest grade Elementary/Secondary (0-12) | completed) College (1-4or 5+) | (Give | kind of work done DO NOT use retire | during most of w | vorking | | , |
| N MILE | I Hygiene. other then "i ent, the Mad | E O | 11 | College (1-401 34) | | homema | ker | | own h | ome |
| <u> </u> | d oth | Be | 17. Father's Name (First, Middle, Last) | | | | | lame (First, Middle, | |) |
| | is marked reumatic ev | 2 | Arthur Cordrey | | 10h M-11 | Add (Chara | | ie Kenney | | Name Tie Code) |
| | it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23s or 28s-f ehow or other treumatic event, the Medical Examinar must be modified at | | 19a. Informant's Name/Relationship (Typ Elaine Moore | | | | | Rural Route Numbe | | tate, Zip Code) |
| | Health tem 27 i | | 20a. Method of Disposition | daughter | Ob. Place of Dispo | O. Box M esition (Name of matory or other place | | Date Date | 1643 20c. Location - C | City or Town, State |
| Page | nt: if i | | t X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) | | | ens Cemet | 1 | /11/06 | Delmar, | DE |
| Saltimor | Department of the Important: if ite any injury or of once. | | 21. Signature of Funeral Service License | | | 2. Name and Addre | | Thomas F | | |
| 2 a | ₫ 5 8 8 | | the Willeman | / | | | | Cambridge | • | 613 |
| | | | 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on | e cause on each line. | | er the mode of dyir | ng, such as card | iac or respiratory ai | rest, | Approximate Interval Between Onset and Death |
| , | ysician Medical | | Immediate Cause (Final disease or condition resulting in death) | PNEUM | | | | | | |
| | kaminer | | | Due to (or as a co | | OF ALZ | H. Will | 0 | | |
| L | | ē | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a co | | OT ALL | ri Win uc | \$ | | |
| cuted | ransit | Examiner | that initiated events c | | | | | | | |
| ou , be executed | physicien and the burial-transit | E | resulting in death) Last | Due to (or as a co | nsequence of): | | | | | |
| o ie | physic s the b | dicai | | | | | | | | |
| DOX DO | ding se as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 3c. If yes, outcome of pr | | _ | | | 23d, Date | of delivery |
| . 9 | e atte | Iclai | in the past 12 months? | 1 Live birth 2 ☐ 4 Pregnant at time | | Ectopic pregnancy Other (specify) | / | | Mont | th Day Year |
| چ <u>د</u> | by th | hys | 9 🗆 Unknown | 9□ Unknown | | | | | | |
| ords, P | igned be de | þ | Part II. Other significant conditions con | tributing to death but no | t resulting in the u | nderlying cause giv | en in Part I. | | | bute to the cause of death? |
| ecords, | been si should b | eted | | | | · · · · · · · · · · · · · · · · · · · | | - | | 3 ☐ Probably 4 ☐ Unknown |
| The taw | s certificete has t irector, page 2 s | Completed | | | | | | 24a. Was autop perfo | an 24b. We pri | ere autopsy findings available ior to completion of cause of eath? |
| | ificete or, pa | e Co | 25. Was case referred to medical | | | | 26 Plans of D | 1 ☐ Yes | 2 1 1 1 | ☐Yes 2☐ No |
| | is cert | To B | examiner? | ospital: | 2 ER/Outpatier | nt 3 DOA Oth | | Home 5 Resid | | assisted (Specify) living |
| ים ה האקרים הי | ih. After this certifice funeral director, p | | 27. Manner of Death 1 ☑Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Yea | ar) 28b. Time o | f 28c. Injur | | | now injury occurre | |
| S S | leath. tor: A the fu | cati | 2 Accident investigation 3 Suicide 6 Could not be | | | | Yes 2 □ No | | | |
| UIVISION I or Attending | after death. I Director: After d in by the funera | Certification: | 4 Homicide determined | 28e. Place of Injury - building, etc. (S | At home, farm, str pecify) | eet, factory, office | | 28f. Location (S City or Tox | Street and Number vn. State) | r or Rural Route Number, |
| Spital | 24 hours after deatl • Funers! Director: etely filled in by the | a C | 29a. Certifier A Certifying Phys | ician: To the best of my | y knowledge, deati | h occurred at the ti | me, date and pla | ice, and due to the | cause(s) and man | ner as stated. |
| 9 | n 24 h | edicai | (Check only 2 Medical Examination) | er: On the basis of exa and manner stated. | mination and/or in | vestigation, in my o | ppinion, death oc | courred at the time, | date and place, ar | nd due to the cause(s) |
| Tota | within 24 hours after To the Funeral Direcompletely filled in by | Σ | 29b. Signature and title of certifier | | | 29c. Licens | | | . 1 . | (Month, Dey, Year) |
| | | | ARD. MD | | | | 3433 | | 11/8/6 | 4 |
| | | | 30. Name and address of person who co | mpleted cause of death | (Item 23a) (Type, | Print) | ieu m | D 21904 | | |
| | Sta | ate | 31. Date filed (Month, Day, Year) | 32. Regintrar's S | Signature | ONUIDIDA | ~ 7 10 | ID 21804 | | |
| , Je | Regist | | NOV 0 9 | 2006 | w K | Sports | | | | |

| | | | 1 - For State Registrer | State of M | arylan | | artmen rtificat | | | and M | lental Hy | /giene | 2111 | 6 | 3765 | 57 |
|---------------------|--|-------------------|---|---|--------------------------------------|------------------------------------|---|------------------------|------------------------------|------------|-----------------------------------|----------------------|---------------------------|----------------------|---|------------|
| | Physici | an | 1. Decedent's Name (First, Middle, La | , | | | | | | | 2. Date of D Month | | y Y | ea.r | 3. Time of Dea | ith |
| | /Medic | | BETTY FARIS | CALLANDER | | | | | | | Month OCTOBE | - | | | 10:30A | М |
| | Examir | ier | 4a. Fecility Name (If not institution, give | | | | | | Location o | f Death | | 40 | : County of | | | |
| | Funeral | | CLAYTON COMFOR' 5. Social Security Number 6.5 | | e (In yrs. | last birthday) | If Under | | If Under 2 | | 8. Date of Bi | irth | MONTGO | | ace (State or Fo | reian |
| г | Funeral Director | | | 1 □ M 2 🗓 F | 8 | | Months | Days | Hours | Min. | (Month, D DEC 1 | ay, Year) | 16 | Count KA | ace (State or Fo ry) NSAS | -gi, |
| | p , | | Usual Residence of Decedent | | 10- 03 | ¥ | | | | | | | | | | |
| | arylan •how | 5 | 10a. State 10b. County | | 10c. CI | y, Town or Lo | | | | | | | | 10 | od. Inside City Li 1 ☐ Yes 2 ☐ | |
| | 28a-f | Director | MARYLAND MONTGOI 10e. Street and Number | MERY | | SILVE | SPRIN 10f. Zip | | | | | 10a Ci | tizen of Wha | | | |
| | with with | | 629 WHITINGHAM DR | IVE | | | 101. Zip | | 904 | | | _ | | | ryr F AMERICA | |
| | 72 hours after death with the Maryland natural; or Iteme 23a or 28a-f ehow iteal Evantrar must be notified at | Funerai | 11. Marital Status | 12. Was Decedent Armed Forces | Ever in U. | .S. 13. | Was Deced | | | gin? (Spe | ecify Yes or N Rican, etc.) | | 14. Race - | America | an Indian, | |
| ထွ | or Ite | | 1 Never Married 2 Married | 1 X Yes 2 □ | No | | ryes,speo 1 ☐ Yes | | n, Mexican Specify: | , Puerto | Hican, etc.) | | Black, Specify: | | _ | |
| 8 | ural', | d by | 3 Widowed 4 Divorced | Year or Dates: | 1944- | 21 | | | | | | | | | | |
| 15 | "nati | iete | 15. Decedent's E (Specify only highest gr | ducation ade completed) | | 16a. Dece | dent's Usua kind of wor DO NOT us | al Occupa rk done d | ition u <i>ring m</i> ost | of worki | ng | 16b. K | and of Busin | ess/Ind | ustry | |
| 12 | J within 72 hours after death with the Maryla jiene. I than "natural", or Iteme 23e or 28e-f eho The Medical Examinar must be notified at | Completed | Elementary/Secondary (0-12) | College (1-4or 4 | 5+) | | 1EMAKER | | ' | | | 70 | N HOME | | | |
| ğ | E T ST | BeC | 17. Father's Name (First, Middle, Last |) | | I IIO | IEPIAKEN | | 18. Mothe | r's Name | (First, Middle | | | | | |
| /lar | | To E | HARRY NELSON FARIS | | | | | | CE | CIL C | RACE HAS | SKETT | | | | |
| Maryland 21215-0036 | s 1 and 2 should f Heelth and Mer Item 27 is marke other traumatic | a d | 19a. Informant's Name/Relationship (| Type, Print) | | 19b. Mailir | ng Address | (Street a | nd Numbe | r or Aura | I Route Numb | oer, City | or Town, Sta | te, Zip (| Code) | |
| - en | is 1 and 2 of Heelth a Item 27 is | | CHESTER L. CALLANDER | R - HUSBAND | 20h B | 629 W | HITING | | RIVE, | | VER SPR | | | | 21 | |
| Baltimore, | ages of of h | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ | | c | emetery, crer | natory or o | ther place | - 1 | | | | ocation - Cit | | | |
| ᆵ | it. Partmer | | 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice | | FT | . LINCOL | | | 1 | 11/15 | ES - RIN | | ENTWOOD | • | | |
| Ba | permit. Pages 1 Deportment of He Important: If Iten any injury or oth | |) De hi | 1_ | | 1 | 1800 N | IEW HA | MPSHIR | E AVE | . SILVE | R SPR | ING, MD | 2090 | 1E, INC. | |
| | Physician /Medical Examiner | 10 | 23a. Part. Ediffrithe disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate | a. MYOCARI Due to (or as | ne. DIAL II aconseq XY ARTI | NFARCTIC uence of): ERY DISE | N | e of dying | , such as (| cardiac o | r respiratory a | arrest, | | _ 1 | Approximate Interval Betweer Onset and Deatl HOUR | |
| 68760, | certificate be executed adding physicien and use as the burial-transit | edicai Examine | Squantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as | a consequ | uence of): | | | | | | | | | | |
| œ. | the death by the atter ached for u | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☒ No 9 □ Unknown | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown | 2 Fetal | Ideath 3 | Ectopic pro Other (sp | | | | | | 23d. Date o Month | | y Day Year | |
| | | by P | Part II. Other significant conditions | contributing to death b | ut not resi | ulting in the u | nderlying ca | ause give | n in Part I. | | 23e. Did | tobacco | use contribu | te to the | cause of death | ? |
| ord | law requires as been sign 2 should be | | | | | | | | | | 1 🗆 | Yes 2 | □No 3[|] Proba | biy 4 <u>X</u> ∏Unkn | own |
| | The la ate hes page 2 | Completed | | | | | | | | | | | deat | h? | sy findings avail pletion of cause 2 No | able of |
| Ę | Physician: this certific ral director, | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | | FD/0 | | Othe | ** | | (Check only | | | | | |
| on of | After fune | tion: To | 27. Manner of Death t 🖒 Natural 5 🗀 Pending 2 🗀 Accident investigatio | 28a. Date of Inju (Month, Da | | 28b. Time of Injury | | 8c. Injury Work | | 2 | ne 5 Res 28d. Describe | | | Specity) | | |
| Divis | al or Atteness after death | Certification: | 3 Suicide 6 Could not be determined | | ury - At ho c. (Specif) | ome, farm, str | eet, factory | , office | | 2 | 28f. Location (City or To | Street ar | od Number o | r Rural | Route Number, | |
| | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by | edicai (| 29a. Certifier 1 Certifying Pt (Check only one) | nysicien: To the best miner: On the basis of and manner st | f examinal | wledge, death tion and/or inv | occurred vestigation, | at the tim | e, date and inion, deat | d place, a | and due to the ed at the time, | cause(s) date and | and manne d place, and | r as sta due to t | ited. the cause(s) | |
| ŀ | within To # | W | 29b. Signature and little of certifier | Keell | ex | MD | 290 | License | number 4 | 4 | 9 | 29d. Da | te signed (M | Ionth, D | ay, Year) | |
| | 12 | | 30. Name and address of person who AUEN Reilly, | completed cause o | th (Item | 1 23a) (Type, | Print) | CA | ve. | 8- | 1, TRE | ese | eick, | Par | 006 172170 | / |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 1 3 2 | 006 32 Registr | ar's Signa | ture | refel) | | 7 | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NoZUU6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0640 AM **Physician** ZEN CHANDLER 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MARGUE ManTozome724 BETHESDA HOSPITAZ 8. Date of Birth (Month, Day, Year Sept 21, 1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🗗 F Pennsylvania Yrs. 85 183-18-8309 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a, State 10b. County 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1X Yes 2 No Director Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20895 9816 Hillridge Drive United States Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after on Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examina and any injury or other traumatic event, the Medical Examina ones. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2K No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Cromwell Lloyd DeLauter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9816 Hillridge Dr. Kensington, MD 20895 John Chandler Sr. / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11-14-06 Rockville,MD Parklawn Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licenses 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failing. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE YULMONARY DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION Esque Itlary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CORONARY KIERY certificate be executed and use as the burial-tran Due to (or as a consequence of): **0640 km** Vital Records, P.O. Box 68760, nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \<u>a</u> 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 2 🙀 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Impatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director; of completely filled in by the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date, signed (Month, Day, Year) 29b. Signature and title of certifier 11/9/06 Monalisari

Registrar

State

Chandle

LOCKS

ROAD, ROCKVILLE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

VISWALINGAM

31. Date filed (Month, Day, Year)

NOV 13

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Barbara Jeanne Jones Chase 8 2006 November 10:50 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 XF 71 579 46 3953 Director Tennesse December 3 1934 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d, Inside City Limits 10b. County 28e-f ehow the Medical Examiner must be notified at MD 1 X Yes 2 No Montgomery Silver Spring Director 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code or items 23a or 3227 Belpre Road 20906 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 P No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) then College (1-4or 5+) Computer programmer US Gov 12 ie marked other permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, Important: If flem 27 Is marked othe any injury or other territorial. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert B. Jones Elizabeth Anna Spaulding 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3716 Seasons Lane, Richmond, Va 23223 Anthony Michael Chase/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 10 1 Burial 2 Cremation 3 Removal from State Washington DC Georgetown University 2006 4 Donation 5 Other (Specify) 21. Signature by Funeral Service License 22. Name and Address of Facility Columbia Mortuary Services once PO Box 58007, Washington DC 20037 Metace Jandon Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASDIVATION

Due to (or as a consequence of): Physician resulting in death) /Medical Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ Year in the past 12 months? Month Day 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No deteched 9 Unknown 9 Unknown á been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death? has autopsy perform certificate 1 Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) mpatient ٩ 2 ER/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? After 1 Certification: 28d. Describe how injury occurred Hospital or Attending 5 Pending Matural 1 Yes 2 No death. investigation 2 Accident within 24 hours after deat 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 2 D0063196 who completed cause of death (Item 23a) (Type, Print) Philip Drive of her Month, Day, Year) State NOV 1 3 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2006 Sylvester V. Chek Nov. 6, 5:01 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda If Under 1 Year | If Under 24 Hrs. Suburban Hospital
Social Security Number 6. Security Number Montgomery 8. Date of Birth (Month, Day, Yea Aug. 1, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours 193-16-7502 86 1920 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits MXYes 2 □ No Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10314 Farnham Drive 20814 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑¥res 2 ☑ No If Yes, Give Year or Dates: Unknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2KNo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Branch Chief Administrator US Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Chek Anna Buchanec 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph J. Chek / Brother 10314 Farnham Dr. Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) St 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Joseph Church Cemet. 11/13/2006 Nanticoke, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fulleral/Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the lisease, or compile ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart value. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, and the sequentially list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2∰No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? res ZZNo Vital 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🖾 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Division or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🖎 Natural To the Hospital or Attendl within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 200 / MO 000 57124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao MD 9715 Medical Center Dr. Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 NOV 13 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** LOUISE 10:28 HATTIE COLLINS NOVEMBOS 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner , MD BAUTIMORE ANDALLSTOWN NORTHWEST HOSPITA L | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 | May 20 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** ^{Year)} 1921 1 □ M 2 🔀 F 85 Yrs. 213-26-2659 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 No Maryland N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 4019 Villa Nova Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: B1ack Be Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker None 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Collins William Whittington ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vanessa V. Chaplin(Daughter) 4019 Villa Nova Rd. Baltimore, Md. 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chews UM Church 11-10-06 West River, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Windame Redese of Beilisons Mortuary, P.A. Lavry B. Reese MO0483 821 West St. Annapolis, Md. 23a. Part1. Enter tife disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MONARY /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, from y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by HEARI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 \(\square\) No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Depatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director. A completely filled in by the fi 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) apt manner stated To the I within 2 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53910 NOV 05, 2006 MD

State Registrar

DHMH 17 Rev 1/2001

MOSPITAL CTR, BALTIMORE MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD, WORTHWEST

32 Registrar's Signat

MAHELHWARI

NOV 0 8 2006

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. FeAMEND#19cperFH11/17/06, Hwy Maryland / Department of Health and Mental Hygiene State Registra AMEND #12+19 perFH11/13/06, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** a M 7, Evelyn Regina November 2006 12:37 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House Montgomery Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Numbe 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 3x1 Days Hours Yrs Director 015-18-8393 88 9, 1918 Oct. Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2€ No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or Items 23a or any injury or other traumatte event, the Medical Examiner must be Is any injury or other traumatte event, the Medical Examiner must be Is any injury or other traumatte. 14615 Deerhurst Terrace 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

15 Yes 25 No. If Yes, Give Year or Date 944-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🙀 No Specify SpecifyWhite þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael McKinnon Regina Demarest 2 19a. Informant's Name/Relationship (Type. Print) 1944 Fillmore Court, Thornton, CO 80121 Melinda E. Cole/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State December 7, Arlington Nat'l 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 2006 rencing Address Coffins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Metastatic Neoplasm of Unknown Primary /Medical resulting in death) Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2√☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page Division or Vital 1☐ Yes 2 X No 1 Tyes 2 🗆 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}\cancel{x}$ Other (Specify)Hospice 1 ☐ Yes 2 X No 2 ER/Outpatient 3 □ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Iniury 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral Di letely filled in 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. noletely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) To the within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) november 7, 2006 H0058032 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

NOV 0 9 2006

31. Date filed (Month, Day, Year)

Cynthia Williams, D.O

0 6001 Muncaster Mill Road, Rockville, MD 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 4:25 PM Barbara Jo Dixon 2006 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Montgomery Rockville 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months 1 ☐ M 2 🛛 F 540-36-0432 75 Director Oct.24,1931 Minnesota Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 1⊠Yes 2 No Director Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mertlal Hygiene.
Intel if item 27 Is marked other than "natural", or items 23a or item 20 or or or the tranmatic event, the Medinal Examiner must be any or other tranmatic event, the Medinal Examiner must be a 1220 Thornden Road 20851 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 ⊠Yes 2 □ No 1950If Yes, Give Black, White, etc. 1 XNever Married 2 ☐ Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 1975 Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered_Nurse Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard A. Dixon ۵ Dorotha Oeder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laverne L. Hill/Life Partner 1220 Thornden Road, Rockville, Md. 20851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 8 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 2006 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. Alexandria, Virginia 21. Signature of Emperal Service Licen 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, DC 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** End Stage Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dehydration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit Inanition resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical IF FEMALE: use 23c. if yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 🖾 No detached the 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Peripheral Vascular Disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed?

1 Yes 2 K No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}$ MOther (Specify) Hospice 1 ☐ Yes 2 ☑ No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 🔀 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the F and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

0

6001 Muncaster Mill Rd. Rockville, Md. 20850

im Milliams Do

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia M. Williams

NOA

09

31. Date filed (Month, Day, Year)

| | | | For Stete Registrar | State of Ma | | artment of Health | | giene Reg. No. 20 | 06 37664 |
|-------------------|--|-------------------------------|--|--|---------------------------|---|---------------------------|---|--|
| 6 | W (4) | | Decedent's Name (First, Middle, | Last) | | - | 2. Date of Do Month | aath Day | 3. Time of Death |
| J. | Physicia /Medic | | Andre | Albert | Deprit | | Novemb | - · · · | |
| | Examin | | 4a. Facility Name (If not institution, | give street and number) | | 4b. City, Town, or Location | of Death | 4c. County | of Death |
| | | | 19119 Roman Way | | | Montgomery | | | tgomery |
| * | Funeral | | | . Sex 7. Ago 1.2XM 2F | e (In yrs. last birthday) | If Under 1 Year If Under Months Days Hours | Min. 8. Date of Bi | av. Year) | Birthplace (State or Foreign Country) |
| | Director | | 534-48-6100 Usual Residence of Decedent | | 80 Yrs. | | April | 10,1926 | Belgium |
| | and | | 10a. State 10b. County | | 10c. City, Town or Lo | ocation | | | 10d. Inside City Limits |
| | daryl f sho | ō | Mantani Mantan | | Montgom | ery Village | | | 1 ☐ Yes 2 🖾 No |
| | 28a- | ec | Maryland Montgot 10e. Street and Number | пету | rionegom | 10f. Zip Code | | 10g. Citizen of \ | What Country? |
| | 3a or | Ö | 19119 Roman Way | | | 20886 | | Unite | ed States |
| | ms 2 | era | 11. Marital Status | 12. Was Decedent | Ever in U.S. 13. | Was Decedent of Hispanic O If Yes, specify Cuban, Mexica | rigin? (Specify Yes or N | | ce - American Indian, |
| 9 | after or Ite | Ē | 1 ☐ Never Married 2 ☐ Marrie | Armed Forces? d 1 ☐ Yes 21€ ? If Yes, Give | No I | 1 ☐ Yes 2 ② No Specify | | Specify | ck, White, etc. |
| 21215-0036 | 72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examener must be notified at | Completed by Funeral Director | 3 Widowed 4 □ Divorced | Year or Dates: | | 163 2 LE 110 Opocii) | | Specin | White |
| 5-0 | 72 h | etec | 15. Decedent's (Specify only highest | | (Give | dent's Usual Occupation kind of work done during mo | st of working | 16b. Kind of B | usiness/Industry |
| 21 | within ene. then | Ig I | Elementary/Secondary (0-12) | College (1-4or 5 | 5+) | DO NOT use retired) | | NIST | i |
| | filed w Hygiel other ti | | 17. Father's Name (First, Middle, La | 5+ | 5 | cientist | her's Name (First, Middle | | |
| and | ntal H od ot | Be | | | | 10.100 | • | rie Car | |
| Ž | should be ind Mental is marked o | 2 | Max Fr 19a. Informant's Name/Relationshi | ancois Dep | | ng Address (Street and Numb | | | |
| Maryland | d 2 s th an th an trau | | Etienne Max Depr | | | | | | Maryland 20886 |
| á, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinet must be notified at ance. | | 20a. Method of Disposition | 10/3011 | 20b. Place of Dispo | osition (Name of | Date | | - City or Town, State |
| Baltimore, | ages int of t: If if | | 1 ☐ Burial 2 【X Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | | 1 | ton Cromatory | . 11/7/2006 | Alexand | dria, Virginia |
| ٧Ę | artme ortan injur | | 21 Signature of Funeral Service Li | | | 2. Name and Address of Faci | | | |
| Ba | permil Depar Impor eny irr | | Merley | 2016 | | East Deer Pa | | | The second secon |
| | | | 23a. Part1. Enter the disease, or c | omplications that caused | the death. Do not en | | | | Approximate Interval Between |
| 1 | Dharinian | | shock, or heart failure. List o | nly one cause on each li | ne. | | | | Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) | a. Pue to (or as | a consequence of): | 1. | , | 1 | years |
| | Examiner | | | Athen | osclenati | c, cardiovas | scular a | isease | 2 years |
| | | Je. | Sequentially list conditions, if any, leading to immediate | Due to (or as | a consequence of): | C TOTAL POLICE | 2 (200) 2.7 | 7 | |
| | kecuted and I-transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | c | | | | | |
| Ö, | death certificate be executed e attending physician and of for use as the burial-transit | E | resulting in death) Last | Due to (or as | a consequence of): | | | | |
| 3760, | ate be ex hysician ihe burial | cal | 3 | d | | | | | |
| 39 3 | n certifica Inding pt use as th | Physician/Med | IF FEMALE: | | | | | | |
| Вох | eath certif attending for use as | an/ | 23b. Was decedent pregnant in the past 12 months? | | 2 Fetal death 3 | Ectopic pregnancy | | | ate of delivery onth Day Year |
| | | sic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Pregnant at 9□ Unknown | time of death 5 | Other (specify) | | | |
| P.0 | that the | | Part II. Other significant condition | s contributing to death b | ut not resulting in the I | inderlying cause given in Part | 11. 23e, Did | tobacco use conf | tribute to the cause of death? |
| of Vital Records, | S L O | t by | | | | , | 1 | Yes 2 XNo | 3 ☐ Probably 4 ☐ Unknown |
| 0 | w require been sign | Completed | | | | | 242 146 | 24h | Wasa autopay findings available |
| 3ec | a SO | ם | | | | · · · · · · · · · · · · · · · · · · · | | opsy | Were autopsy findings available prior to completion of cause of death? |
| alF | r. The icate h | | | | | | 1 ☐ Yes | 2 No | 1 ☐ Yes 2 No |
| Z. | Physician: 1 this certifical al director, p | Be | 25. Was case referred to medical examiner? | Hospital: | | | ce of Death (Check only | | |
| o | Physician: r this certific ral director, | ٦. | 1 Yes 2 No | 1 Linpatie | | | 7 | idence 6 Oth how injury occur | |
| o | gr ff er | ţ | 1 Natural 5 ☐ Pending | | ý Year) Injury | of 28c. Injury at Work? M 1 □ Yes 2 □ | | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | |
| Division | Attending r death. | fica | 3 ☐ Suicide 6 ☐ Could no | ot be 28e. Place of Inj | ury - At home, farm, st | reet, factory, office | | | ber or Rural Route Number, |
| <u>S</u> | after Dire | Certification: | 4 Homicide | building, et | c. (Specify) | | City or 10 | own, State) | |
| | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu | aic | | | | h occurred at the time, date a | | | |
| | n 24 he Fu | edical | (Check only 2 Medical E | xaminer: On the basis o and manner st | | vestigation, in my opinion, de | | | |
| 7 | Withi. To tl | ž | 29b. Signature and title of certifier | 7 0 | M. Mar | 29c. License number | 710 | 29d. Date signe | ed (Month, Day, Year) |
| | 4 | 1 | Patricia | 10ms/Ro | May, Me | x 10019 | 16 | NOV, | T, 2006 |
| | I | | 30 Name and address of person w | ho completed cause of o | death (frem 23a) (Type | Print) / - // | Dil. O | IOND 1 | 11. Int |
| | | | Patricia To | nsko Nay, | MID) 1111 | 7 KOCKVILLE | rike, GT | vu, Nock | VIIIE, 111 20552 |
| | Sta Regist | ate rar | 31. Date filed (Month, Day, Year) NOV 0 9 | 2006 32 Registr | rar's Signature | arks) | , | | |
| | 9.31 | 11.5 | 1101 0 | R. 36 78 11 6 14 | | | | | |

06-08731

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Jade K. Duongwalker 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1230 hrs Medical Examiner November 16, 2006 Kim Duong-Walker Jade 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Shady Grove Advestist Hospital Rockville Montgomery . Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** Months Hours Director Country) 18 1 M 2 X F Yrs 8 Feb. 26, 2006 MD. 214-75-0445 Usual Residence of Decedent 10d. Inside City Limits any 10a State 10b. County 10c. City. Town or Location Yes 2 X No 23a or 28a-f show notified at once. Montgomery Village Maryland Montgomery hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code Og. Citizen of What Country 20886 United States 18904 Smoothstone Way, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Asian/African 1 Yes 1 Yes 2 X No specify. Widowed Divorced f Yes, Give Year Specify: American "natural", 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) t. Pages I and 2 should be filed within 72 Iment of Health and Mental Hygiene.
rtant: If item 27 is marked other than "ro other traumatic event, the Medical I MD 21215-0036 N/A 0 N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) C. Walker Thuyminh Duong Lester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19a Informant's Name/Relationship (Type, Print) 18904 Smoothstone Way, #4, Montgomery Village, MD. Thuyminh Duong/Mother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 11/21/2006 Alexandria, Virginia Donation 5 Other Specify 22. Name and Address of Facility DeVol Funeral Home al Service Li gnature of Fune East Deer Park Dr., Gaithersburg, MD. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure List only one cause on each line /Medical Death Sudden infant death syndrome Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and #1,perME, g864, 2/21/0/ #23a,27,perME, g864, 2 ian/Medical ttending physician a r use as the burial -X UNPENDED AMENDED X 707 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Physic 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) the Hospital or Attending Physician: Be examiner? Hospital: 1 Other Nursing Home 5 DOA Inpatient 2 V ER/Outpatient 3 Residence 6 Other this 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After Manner of Death 28b. Time of Injury Certification: 1 X Natural Yes 2 No 5 Pending I Director: ed in by the f 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide determined Funeral Homicide 29a Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the Lo and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 17, 2006 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Manth egistrar's Signatul State 2006

Registra

| | | - | For State Registrar | State of M | aryland / | - | artment <i>tificate</i> | | | and M | | jiene | 006 | 37666 |
|--------------------------------|---|---------------------|---|--|-------------------------------|-------------------------|---|------------------------|---------------------------------|--------------------------|--|---------------------------|--|---|
| | | | 1. Decedent's Name (First, Middle, Las | t) | | | | | | | 2. Date of Dea Month | th Day | Year | 3. Time of Death |
| | Physicia /Medic | | Joan Mar | ie D | eBold | 2 | | | | | Nov. 1 | | | 9:00am ^M |
| | Examin | _ | 4a. Facility Name (If not institution, give | street and number) | | | , | | Location o | | | 4c. Co | ounty of Death | 1 |
| | | | Casey House | | | | | | ille | | | | ontgo | |
| | Funeral Director | | | 7. Ag □M 2 ½ () F | 73 | Yrs. | If Under Months | Days | If Under: Hours | Min. | 8. Date of Birth (Month, Day 2/02/ | 1933 | 9. Birth Con New | pplace (State or Foreign untry) Jersey |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, To | own or Lo | cation | | | | | | | 10d. Inside City Limits |
| | a Mary | ctor | MD MOntgo | nery | Roc | kvil | .le | | | | | | | 1 ☐ Yes 2 🄀 No |
| | 3s or 28 | I Dire | 10e. Street and Number 14000 Parkdale | Road | | | 10f. Zip | | 0853 | | | - | n of What Col USA | untry? |
| 336 | ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-f show if item 27 is marked other than "natural", or itema 25a or 28a-f show or other traumatic event, in Madical Exam recruited to molified at | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates: | | 1 | Was Deced f Yes, spec | | spanic Origin, Mexican Specify: | gin? (Spe , Puerto f | cify Yes or No- Rican, etc.) | | Race - Amer Black, White pecify: W | |
| Baltimore, Maryland 21215-0036 | within 72 horens. than "naturalized in | Completed | 15. Decedent's Ed (Specify only highest grader) | | | (Give life. L | dent's Usua kind of wor DO NOT us | k done d e retired, | ition <i>uring</i> mosi) | of workir | ng | | of Business/I | • |
| 121 | e filed within al Hygiene. other than " | e Con | 17. Father's Name (First, Middle, Last) | 4 | | Sc | ient | ıst | 18. Mothe | r's Name | (First, Middle, | | | aboratory |
| yland | should be nd Mental marked o | To Be | Daniel Collin | | | | | | Kat | hlee | n McG | owan | | |
| Mar | nd 2 sho alth and 27 is m r traum | | 19a. Informant's Name/Relationship (7 Francis DeBold) | | | | _ | | | | Route Numbe | | | |
| lore, | Pages 1 and 2 nent of Health a int: If Item 27 is iry or other train | | 20a. Method of Disposition 1 Deurial 2 Commation 3 December 2 | nemoval from State | 20b. Place | e of Dispo | sition (Nam natory or of ake | e of | 9) | D | ate | 20c. Loca | tion · City or 1 | Town, State |
| altin | permit, Page Department of Important: If eny injury or once. | 1 | 4 Donation 5 Other (Specify 21. Signature of runeral Service acom | - 21 | 0.10 | _ | | | | | FUNERA | | | |
| | 88188 | - 8 | July Steer | disations that cause | d the death. F | 92 | 41 C | <u>olu</u> | mbia | BLv | d.Silv | ver S | Spring | g, Md20910 Approximate |
| | Physician /Medical | | 23a. Part1. Enter the disease, or come shock, or hear failure. List only of Immediate Cause (Final disease or condition resulting in death) | a. Pel | vic C | ance | | or dying | g, sucii as | cardiac of | | | | Interval Between Onset and Death |
| | Examiner | | Sequentially list conditions | b | a consequen | ce of): | | | | | | | | |
| | uted I Insit | Examiner | Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury | | a consequen | ce of): | | | | | | | | |
| 8760, | sate be executed obysicien and the burial-transit | al Exa | that initiated events resulting in death) Last | c. Due to (or as | a consequen | ce of): | | | | | | | | |
| 687 | physicate s the | edical | | d | | | | | | _ | | | | |
| .O. Box 6 | he death certificate be executed the attending physicien and shed for use es the burial-transit | Physiclan/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown | 2 Fetal de | ath 3 | Ectopic pre Other (spe | | | | | 230 | d. Date of delif Month | very Day Year |
| Ω. | law requires that the de as been signed by the a 2 should be detached f | by | Part II. Other significant conditions co | ontributing to death b | out not resultin | ng in the ur | nderlying ca | tuse give | n in Part I. | | | bacco use | | the cause of death? |
| Ö | require been sig should t | etec | | | | | | - | | | | | | |
| of Vital Records, | The ate h page | Completed | | | | | | | | | 24a. Was a autop: perfor | sy | prior to c death? | opsy findings available ompletion of cause of |
| Vita Vita | Physician: T this certifical ral director, p | Be | 25. Was case referred to medical examiner? | Hospital: | | | | Oth | _ | | (Check only or | | | |
| o | Phys this al di | ۲: ا | 1 ☐ Yes 2 1 No 27. Manner of Death | 1 Inpati | ent 2 ER/ | Outpatien b. Time of | | | 4 Nu | - | ne 5 Resid | | | ny hospice |
| ion | Attending in death. | atlon | 1 ☒Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Da | y Year) | Injury | М | Bc. Injury Work | :?`` ∕es 2 🔲 I | | | ow anjury c | 0001100 | |
| Division | al or Attence after death Director: d in by the | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 286. Place of in | ury - At home c. (Specify) | , farm, str | eet, factory | , office | | 2 | 8f. Location (S City or Tow | treet and h n, State) | lumber or Ru | ral Route Number, |
| | To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by | edical C | 29a. Certifier 1 A Certifying Ph (Check only one) 2 Medical Exam | ysician: To the best liner: On the basis of and manner st | f examination | dge, death and/or in | occurred a | at the tim | e, date an pinion, dea | d place, a th occurre | nd due to the ded at the time, of | ause(s) an late and pl | d manner as ace, and due | stated. to the cause(s) |
| | To the within 2 To the complet | Me | 29b. Signature and title of certifier | | | | 29c | License | number | | ż | | igned (Month | • |
| | 0 | | Kynthia m | Willia | ms; Di | | 1 | 400 | 580 | 32 | | гои | 7.11,2 | 2006 |
| | | | 30. Name and address of person who compared the Cynthia M.Wil | · | | | | aste | er Mi |]] | Road P | ockv | ille | Md 20855 |
| | Sta Registr | | 31. Date liled (Month, Day, Year) | | rar's Signature | Some | whi | | | | | | | · · · · · · · · · · · · · · · · · · · |

| | | | For State Registrar | State of Maryland | | rtment of F | | Mental Hy | 000 | 6 37667 |
|------------------|--|----------------|--|--|-------------------------------|--|--|--|---|---|
| ì | Physici | an | 1. Decedent's Name (First, Middle, Last | | | | | 2. Date of De Month | eath Day Ye | 3. Time of Death |
| y. | /Medio | cal | Joan Louise Dic 4a. Facility Name (If not institution, give | | | 4b. City, Town, o | r Location of Deat | | dc. County of I | |
| | Funeral Director | | 280-16-0994 | | st birthday) Yrs. | Silver If Under 1 Year Months Days | Spring If Under 24 Hrs Hours Min. | | av. Yearl | omery Birthplace (State or Foreign Country) Ohio |
| | /land ow | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, | Town or Lo | cation | | | | 10d. Inside City Limits |
| | Ba-f sh | Director | Maryland Montgom | nery | Silve | r Spring | | | | 1 ☐ Yes 2 🔼 No |
| | with th | Dire | 10e. Street and Number 10101 Greeley Ave | anu o | | 10f. Zip Code | 20902 | | 10g. Citizen of Wha | |
| 36 | is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 ② Widowed 4 □ Divorced | 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give | | Vas Decedent of H f Yes, specify Cuba □ Yes 218 No | lispanic Origin? (S an, Mexican, Puer | Specify Yes or No to Rican, etc.) | 0- 14. Race - A | American Indian, White, etc. |
| 21215-0036 | within 72 hour ene. than "natural' he Medical Ex | Completed b | 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) | Year or Dates: ucation de completed) College (1-4or 5+) | (Give life. L | lent's Usual Occup kind of work done OO NOT use retired | oation during most of wo d) | rking | 16b. Kind of Busine | |
| 121 | filed wi Hygier Sther the | | 17. Father's Name (First, Middle, Last) | 2 | Se | cretary | 18. Mother's Na | me (First, Middle | Vitro e, Maiden Surname) | |
| auc | ild be fental I ked of | To Be | Louis Scalzi | | | | | ie Genti | • | |
| Maryland | 2 should be and Mental is marked of aumatic ev | | 19a. Informant's Name/Relationship (7) | ype. Print) | 19b. Mailin | g Address (Street | and Number or R | ural Route Numb | er, City or Town, Sta | te, Zip Code) |
| | Pages 1 and 2 nent of Health int: If item 27 i | | Patricia Louise I 20a. Method of Disposition 1 3 Burial 2 Cremation 3 F | 20b. Pla ce Removal from State | nce of Dispos metery, cren | 1 Greeley sition (Name of natory or other place even Cemete | nov | Date ember 15 | Spring, 20c. Location - City | or Town, State |
| Baltimore, | permit. Pages Department of Important: If it any Injury or o | | 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens | | 22 | r ^{Name} ards ^{Addre} | ss of odly in | s Funera | 1 Home In | ring, Maryland c. ring, MD 2090 |
| | Physician /Medical | i Vi | 23a. Part1. Enter the disease, or comp shock, or heart fallure. List only o immediate Cause (Final disease or condition resulting in death) | one cause on each line. a. Rheumatic Hea | rt Di | | ng, such as cardia | c or respiratory a | arrest, | Approximate Interval Between Onset and Death Years |
| 8760, | cate be executed physician and the burial-transit | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last | b. Due to (or as a conseque Due to (or as a conseque Due to (or as a conseque d. | ence of): | | | | | |
| .O. Box 68 | eath certifi attending for use as | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🛣 No 9 □ Unknown | 23c. If yes, outcome pf pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de | death 3 | Ectopic pregnancy Other (specify) | / | | 23d. Date of Month | delivery Day Year |
| σ | w requires that the d been signed by the should be detached | þ | Part II. Other significant conditions co Hypothyroidism | entributing to death but not result | ting in the ur | derlying cause giv | en in Part I. | | | e to the cause of death? Probably 4 □Unknown |
| or Vital Records | The la ate has page 2 | Completed | | | - | | | 24a. Was auto perfo 1∐ Yes | | |
| Z. | Physiclan: Th this certificate ral director, pag | o Be | 25. Was case referred to medical examiner? 1xxx es 2 No | Hospital: 1 ☐ Inpatient 2 🔀 E | R/Outnatien | Oth | or. | ath (Check only | one) idence 6 □Other (| Property d |
| ion or | dlng J. After fune | ation: To | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | | 28b. Time of Injury | 28c. Injur Wor | | | how injury occurred | ъреспу) |
| Division | in Direct | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of injury - At hom building, etc. (Specify) | | | | City or To | wn, State) | r Rural Route Number, |
| | e Hospital 24 hours a e Funeral letely filled | edical | 29a. Certifier †☐ Certifying Phy (Check only one) | rsician: To the best of my know Iner: On the basis of examination and manner stated. | ledge death on and/or inv | occurred at the tire tirestigation, in my contraction, in my contract to the contract of the c | me, date and plac opinion, death occ | e, and due to the urred at the time | cause(s) and manne , date and place, and | r as stated. due to the cause(s) |
|) | To the I within 2. To the I complet | Me | 29b. Signature and title of Certher | CS | 2 | 29c. Licens D36 | e number 5046 | | 29d. Date signed (M November | |
| | | | John J/ Merrendino, | M.D 1021/5 Fe | | d Road, | #405, Be | thesda, | MD 20817 | |
| | Sta Registr | _ | 31. Date filled (Monty, Day, Year) NOV 1 3 7 | 32. Pogistrar's Signatu | 4 | arke | | | | |

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician CONSTANCE MARIE DISPENZA 31, 3:06 OCTOBER 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LAUREL REGIONAL HOSPITAL PRINCE GEORGE'S LAUREL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 □ M 2 🛛 F Yrs. FRANCE Director 579-01-6755 JANUARY 20, 1907 99 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic sysnt, the Modical Examinar must be notified at 1 ☐ Yes 2 🕅 No Directo ODENTON MARYLAND ANNE ARUNDEL 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 8515 PINE MEADOWS DRIVE 21113 death Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black. White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: ð 3 ♥Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Depertment of Health and Mental Hygiene. Important: If tem 27 is marked other than "ns any injury or other traumatic avant, It a Mexit once. Elementary/Secondary (0-12) College (1-4or 5+) CLOTHING STORE SALES CONSULTANT 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be GUISEPPA BARRANCO PIETRO MICIOTTO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8515 PINE MEADOWS DRIVE, ODENTON, MARYLAND 21113 AUGUST S. DISPENZA - GRANDSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SILVER SPRING, MARYLAND GATE OF HEAVEN CEMETERY 11/11/2006 21. Signature of Funeral Service Licensee 22, Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 ant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** CARDIAC ARRHYTHMIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) page 2 should be detached ☐ Yes 2 🖾 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2 🗆 No 1 ☐ Yes 2 X No 1 Yes To the Hospital or Attending Physician: funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☑ No 2 X ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending 1 Yes 2 No М within 24 hours after death. 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0054566

Registrar DHMH 17 Rev 1/2001

State

SUNITHA BHOGAVILLI, M.D., 1220A EAST JOPPA ROAD, SUITE 230, TOWSON, MARYLAND 21286

32 Registrar's Signature

NOVEMBER 1, 2006

31. Date filed (Month, Day, Year)

13

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

| | | | i icase | Ctota of Ma | | | | | | | | _ | | |
|-------------|--|------------------|---|---|--------------------------|-------------------------|---|-----------------------------|--------------|----------------------------|-------------------------|--------------------------------|---|---|
| | | | 1 _ For State | State of Ma | iryiand | • | | | | | | | 37669 | |
| | | | Registrar | -41 | | Cel | rtificate of | Deam | | Date of De | | 2006 | | _ |
| | Physicia | an | 1. Decedent's Name (First, Middle, Las | sr) | n | AV | | | 2 | Month | Day | Year | 3. Time of Death | |
| | /Medic | al | REGINA | | D, | AY | # 0" T | | 10 11 | // | | | , | |
| | Examin | er | 4a. Facility Name (If not institution, give WASHINGTON AC | | 1050 | TA | 4b. City, Town, o | | | 20 | | County of Deat | | |
| | | | 5. Social Security Number 6. S | | (In yrs. las | | If Under 1 Year | | | . Date of Birt | | 20010 | | _ |
| | Funeral Director | | | _M 2∑F | 74 | Yrs. | Months Days | Hours | Min. | (Month, Da | y, Year) | | hplace (State or Foreign | |
| | | | Usual Residence of Decedent | | | | | | | 1/5/19 | 32 | wası | nington, DC | _ |
| | yland | | 10a. State 10b. County | | 10c. City, | Town or Lo | ocation | | | | | | 10d. Inside City Limits | |
| | Mar Mar | jo | Maryland Montgome | ery | Tako | oma Pa | ark | | | | | | 1X☐Yes 2☐No | |
| | death with the Maryland me 23a or 28e-f show I'must be notified at | Director | 10e. Street and Number | | | | 10f. Zip Code | | | | 10g. Citi | zen of What Co | untry? | |
| | 15 wi | ai | 7525 Carroll Aver | nue | | | 209 | 12 | | | | USA | | |
| | dea dea | Funerai | 11. Marital Status | 12. Was Decedent 8 Armed Forces? | ver in U.S. | 13. | Was Decedent of H | lispanic Ori an. Mexicar | igin? (Speci | y Yes or No | - | 14. Race - Ame Black, White | rican Indian, | |
| õ | or it | | 1 Never Married 2 Married | 1 ☐ Yes 2 🔯 N If Yes, Give | 0 | | 1 ☐ Yes 2 🗓 No | | | | | Specify: | White | |
| 2-003e | d within 72 hours after death with the Marylan jiene. Then *naturel; or iteme 23a or 28a-f show the Madical Examinar must be notified at | d by | 3 X Widowed 4 Divorced | Year or Dates: | | | | | | | | | | |
| | net | Completed | 15. Decedent's Ed (Specify only highest gra | ducation de completed) | | 16a. Dece | dent's Usual Occup kind of work done DO NOT use retired | ation during mos | t of working | | 16b. Kir | nd of Business/ | Industry | |
| Z | within 72 ene. then ene | d L | Elementary/Secondary (0-12) | College (1-4or 5 | +) | | | <i>a)</i> | | | Dri | ntina | Dudrets | |
| N | Hygid Hygid Sther ent, | 3 | 17. Father's Name (First, Middle, Last) | | | Вос | kbinder | 18. Mothe | er's Name // | First, Middle, | | | Private | _ |
| ⊑ : | a la b | Be | Joseph A. Parise | | | | | | | | | | | |
| > | hould nd Men marke maric | ြ | 19a. Informant's Name/Relationship | | | 19b. Mailir | ng Address (Street | | | Schm | | r Town State 2 | 7in Code) | - |
| g Z | ith ar trau | | Dorothy Saxty - C | | | | Misty D | | | | | | -p 00d0/ | |
| ō, | s 1 and 2 should f Health and Mer item 27 ie marke other traumatic | | 20a. Method of Disposition | Ousin | 20b. Plac | ce of Dispo | sition (Name of matory or other place | Log L | annam Dat | | 2070 20c. Lo | cation - City or | Town, State | _ |
| Baltimore, | 80= 5 | | 1 ABurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif | | Gate o | netery, crem of Hear | ven Cemete | | 11/13/ | 2006 | S 1 1 1 | ver Snr | ing, Maryla | n |
| ₫ | | - } | 21. Signature of Euneral Service Licer | - | | | | 1 | | 1 | | _ | | |
| n | Departition of the post of the | | 11.4 | 1/2 /7/ | 1/3/2 | 23 4 | 2. Name and Addre | imore | y Gaso | urct | uner | al Home | , P.A. | |
| | | - | 23a. Part1. Enter the disease, or som shock, or heart lailure. List only | plications that caused | the death. | | | | | | | ire, MD | Approximate | - |
| * | Nevalatan | | shock, or heart lailure. List only Immediate Cause (Final | | | | | | | | | | Interval Between Onset and Death | |
| | Physician /Medical | | disease or condition resulting in death) | Due to (or as | SUL | nce of | 74 CARL | 21001 | BUL | AR | 1113 | EASE | | _ |
| | Examiner | Ì | | 200 10 (0) 03 1 | CONSEQUE | 1100 017. | | | | | | | | |
| | | ler | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury | Due to (or as a | conseque | nce of): | | | | | | | | - |
| | uted d ansit | Examiner | Cause (Disease or injury that initiated events | C | | | | | | | | | | |
| , | be executed icien and burial-transit | | resulting in death) Last | Due to (or as | conseque | nce of): | | | | | | | | _ |
| - | 0 0 | cal | (| d | | | | | | | | | | |
| Q | certifica Iding ph | Med | | | | | | | | | | | | _ |
| X Q Q | in cer endir r use | 2 | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome 1 ☐Live birth | | | Ectopic pregnancy | , | | | 2 | 23d. Date of del | , | |
| <u>.</u> | deal | sicis | in the past 12 months? 1 ☐ Yes 2 ☐ No | 4☐Pregnant at 9☐Unknown | | | Other (specify) | | | | | Month | Day Year | |
| J. | at the | by Physician/Med | 9 ☐ Unknown | | | | | | | | | | | |
| o, | ilcien: The law requires that the death certificate has been signed by the atter rector, page 2 should be detached for u | by | Part II. Other significant conditions of | ontributing to death bu | t not resulti | ing in the u | nderlying cause giv | en in Part I. | | | | | the cause of death? | |
| Hecords, | equir sen si ould | ted | | | | | - | | | 101 | 'es 2[| □No 3□Pr | obably 4 Hunknown | |
| ပ္မ | as be | Completed | | | | | | | | 24a. Was autop | | 24b. Were au | topsy findings available completion of cause of | |
| | The ste h | E | | | | | | | | perfo | med? | death? | | |
| VItal | ien: rtific | Be | 25. Was case referred to medical examiner? | | | | | 26. Place | of Death (| Check only o | | | | - |
| > - | 5 v 5 | 2 | 12 Yes 2 No | Hospital: 1 ☐ Inpatie | nt 2 EF | 2/Outpatier | nt 3 DOA Oth | er: 4□Nu | ırsing Home | 5 ☐ Resid | lence 6 | Cther (Spec | cify) | |
| | ng Pi | | 27. Manner of Death 1/□Natural 5 □ Pending | 28a. Date of Injur (Month, Day | Year) 2 | 8b. Time of | f 28c. Injur Wor | y at k? | 28 | d. Describe h | ow injury | occurred | | |
| 0 | Attending r death. ector: After by the fune | atle | 2 Accident investigation | 1 | | | | Yes 2 | No | | | | | |
| DIVISION | r Att | Certification: | 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined | 28e. Place of Inju- building, etc | ry - At hom (Specify) | e, farm, str | eet, factory, office | | 28 | Location (S City or Tox | street and n, State) | d Number or Ru | ıral Route Number, | |
| ב | ital o | | | | | | | | | | | | | |
| | To the Hospital or Attending Phywitin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral | Medical | Check only 2 Medical Exar | ysician: To the best on niner: On the basis of | examinatio | edge, deatl | h occurred at the tir | ne, date an | d place, and | d due to the | cause(s) | and manner as | stated. to the cause(s) | |
| | To the P within 24 To the F complete | Ved | one) | and manner sta | ted. | | | | | | | | | |
| | Veith Con | - | 29b. Signature and title of certifier | // | | | 29c. Licens | ^ | | | | e signed (Monti | _ | |
| Ţ | 1 | | | ~ mo | | | | 603 | 19 | | / | 1,08 | 2006 | |
|) | (6) | | 30. Name and address of person who | completed cause of de | 1 . | | | | , | | | . 7 | | |
| | | | 31. Date liled (Month, Day, Year) | 32. Registra | T IV | ME | | arrol | LI Ave | ., Tak | coma | Park, N | D 20912 | _ |
| | Sta | te ar | NOV 1 2 2006 | Jaz. megistra | . s olgnatul | 1 . 1 | 2 | | | | | | | |

| | | | 1 - State Registrar | | | Cer | tificate | of D | eath | | Reg. N | lo. | | 0,0,0 |
|-------------------------------------|--|----------------|---|--|--------------------------|---------------------------|--|-----------------------------|-----------------------------------|------------------------------|------------|---------------------|--|-------------------------------------|
| 4 | · Starte | | 1. Decedent's Name (First, Middle, L | ast) | | | | | | 2. Date of Month | Death | Day | Year | 3. Time of Death |
| | Physici /Medio | | Rebecc | a E. Da | avis | | | | | Nov | | th 20 | | 8:05A. M |
| | Examir | | 4a. Facility Name (If not institution, gi | ve street and number) | | | 4b. City, To | wn, or L | ocation of Dea | th | 4 | c. County | of Death | |
| | | | Clinton Nursing | | | | Clin | | | | | rince | | |
| | Funeral | | | Sex 7. Ag | e (In yrs. last b | ,, | If Under 1 Months [| Year Days | If Under 24 Hrs Hours Min | . (Month, | Day, Yea | (r) | 9. Birthp | place (State or Foreign htry) |
| | Director | | 579 50 5909 Usual Residence of Decedent | X | 90 | Yrs. | | | | 10/1 | 1/19 | 16 | Vir | ginia |
| | and | | 10a. State 10b. County | | 10c. City, Tox | wn or Loc | cation | | | | | | 1 | 0d. Inside City Limits |
| | f aho | ō | D.C. | | Washi | ngto | n,D.C. | • | | | | | | 1⊠Yes 2□No |
| | the the | Director | 10e. Street and Number | | | | 10f. Zip Ci | ode | | | 10g. (| Citizen of W | Vhat Cour | ntrv? |
| | with Se or | ٥ | 419 Jefferson S | t.N.E. | | | | | 20011 | | | USA | | , |
| | death ms 2: | Funeral | 11. Marital Status | 12. Was Decedent | Ever in U.S. | 13. V | Vas Deceder | nt of Hisp | panic Origin? (S Mexican, Puer | Specify Yes or | No- | | - Americ | can Indian, |
| (O | ifter of | 교 | 1 ☐ Never Married 2 ☐ Married | Armed Forces? | | | | _ | | to Rican, etc.) | | 10.1 | k, White, | |
| e e | el', o | þ | 3 XWidowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | 1 | ☐ Yes 20 | <u>N</u> No | Specify: | | | Specify | : Bla | ack |
| 20 | within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ahow he Medical Examinat rusal be notilised at | Completed | 15. Decedent's E (Specify only highest g | ducation | 168 | a. Deced | ent's Usual (| Occupati | ion ring most of wo | rkina | 16b. | Kind of Bu | isiness/In | dustry |
| 2 | thin . | npie. | Elementary/Secondary (0-12) | College (1-4or | 5+) | life. D | O NOT use | retired) | ring most of wo | iknig | F1 | lower | Shor | |
| 2 | w bed w ygien t, th | Š | 12 years | 2 years | | F10 | rist | | | | | | | |
| p | tal H d oth | Be | 17. Father's Name (First, Middle, Las | t) | | | | | 8. Mother's Na | • | lle, Maide | n Sumam | θ) | |
| <u>y</u> | Men Men arka | ၉ | Lazarus Reid | | | | | - 1 | Thelma | | | | | |
| , Maryland 21215-0036 | tnd 2 sh elth and 127 is m pr treum | | 19a. Informant's Name/Relationship Eleanor J. King | | | | | | d Number or R Dr. Oxo | | | | State, Zip | Code) |
| Baltimore, | permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f ahow any injury or other treumatic avent, the Medical Examinat must be notified at ance. | | 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec | | RIVER | of Dispos | sition (Name patesy of othe PARK | of er place) | 11/ | Date 9/2006 | | Location - ERDAI | | |
| Ħ | nit. F artme ortan injur | | 21. Signature of Figneral Service Lice | | | 22. | Name and | Address | of Facility | | | | | |
| B | Den imp | | K /weins | Smell | 10 | | | | of Facility NES FUNI | | | 00017 | | |
| | | | 23a. Page Enter the disease, or cor | nplications that cause | the death. Do | not ente | the mode of | h SI of dying, | N.E. I | VASH., D c or respiratory | arrest, | 20017 | | Approximate |
| | Physician | | shock, or heart failure. List onfi Immediate Cause (Final | | | | | | | | | | - 1 | tnterval Between Onset and Death |
| | /Medical | | disease or condition resulting in death) | | YOCARDI a consequence | | FARCT1 | LON | | | | | | |
| | Examiner | | 1 | | ROSCLER | | CARDI | OVA | SCULAR | DISEASE | : | | | |
| | | Je. | Sequentially list conditions if any, leading to immediate | b. Due to (or as | a consequence | of): | · | | | | | | | |
| | uted d ansit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | | | |
| ó | certificate be executed nding physicien end use as the burial-transit | Exa | resulting in death) Last | Due to (or as | a consequence | of): | | | | | | | | |
| 68760, | ysicie ysicie | cai | | d | | | | | | | | | | |
| | tifical ig ph | Medical | 3 | | | | | | | | | | | |
| Division of Vital Records, P.O. Box | The law requires that the death certificate be executed ate hes been signed by the ettending physicien end page 2 should be detached for use as the burial-transit | Physician/N | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 23c. tf yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 Fetal deat | | Ectopic preg Other (speci | | | | - | 23d. Date Mon | e of delive | Day Year |
| ۵. | that I ed by deta | Ph | Part II. Other significant conditions | contributing to death b | ut not resulting | in the un | derlying caus | se given | in Part I, | 23e. Di | d tobacco | use contr | ibute to th | ne cause of death? |
| sp | uires l signe id be | d by | CONGESTIVE HE | ART FATLUR | E | | | | | 10 | Yes | 2 🗆 No | 3 🗌 Prob | ably 4 Q Unknown |
| Ö | w requir been si should | ete | CHRONIC OBSTR | | - | DISE | ASE | | | 24a. W | 20.00 | 245 1/ | Voro auto | psy findings available |
| Re | ne la s hes ge 2 | Completed | DIATED CARRIO | AND A THIN | | | | | | au | topsv | D | rior to cor | npletion of cause of |
| <u></u> | | e Co | DIATED CARDIO | MIOPAIHI | | | | | | | | lo 1 | Yes | 2 No |
| ⋚ | ysician: The i is certificete he director, page | 8 | examiner? | Hospital: | | | •□ | Other: | 26. Place of De | | | . = . | | |
| ō | Attending Physician: or death. actor: After this certific by the funeral director. | 2 | 27. Manner of Death | 28a. Date of Inju (Month, Da | | Time of | | 1 | 4 ZFNursing F | lome 5 ☐ Re | | | | 1) |
| o | or Attending after death. Diractor: After in by the fune | tior | 1 Natural 5 Pending 2 Accident investigation | | y Year) | Injury | М | lnjury a Work? 1 □ Ye | s 2 No | | | , | | |
| isi | Atter dea ctor y the | fica | 3 ☐ Suicide 6 ☐ Could not | 28e. Place of thi | ury - At home, f | arm, stre | et, factory, o | ffice | | 28f. Location | (Street a | and Numbe | er or Rura | l Route Number, |
| ă | after Dira | Certification: | 4 Homicide | building, et | c. (Specify) | | | | | City or 1 | own, Sta | te) | | |
| | To the Mospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral | | 29a. Certifying P | hysician: To the best | of my knowledg | e, death | occurred at | the time, | , date and place | e, and due to th | e cause(| s) and mar | nner as st | ated. |
| | ne Ho n 24 l | Medicai | (Check only 2 Medicat Exa | miner: On the basis o and manner st | f examination a ated. | nd/or inv | estigation, in | my opin | nion, death occi | urred at the tim | e, date a | nd place, a | ind due to | the cause(s) |
| | To the within 2 To the complet | Ž | 29b. Signature and title of certifier | 7 | | | 29c. L | icense r | number | | 29d. D | ate signed | (Month, | Day, Year) |
| | | | Walin VI | ine | | | 1 | 03 | (W6 | | 1 | 1 New | the s | 246 |
| 2 | (5) | | 1/11: | completed cause of o | | | Print) | ום, ו | imcla | 2001 | | it i | IARL. | ytes my |
| | Sta | | 31. Date filed (Month, Day, Year) | | ar's Signature |) ا م ^ر اور | 701 | 10 | ואין | 1 10/1/11 (| , , , | · · W | \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | 7117) |
| | Registi | ar | NOV 13 2006 | Deren 1 | O. 1000 | ALL D | | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink 06-08321 State of Maryland / Department of Health and Mental Hygiene Terrell Dixon Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Příysician/ Month Day November 3, 2006 0009 hrs Dixon Terrel1 Maurice Medical Examiner 4c County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center 8 Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Washington If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs last birthday) **Funeral** May 11, 1984 Months Hours Min 22 Country) D. C. Director 220-25-6670 XX_{M} 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1XX Yes 2 No Prince Georges Bowie 28a-f show Maryland 23a or 28a-f shonorified at once. ges I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 20715 London Lane 14542 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: Black Yes 2X No specify Divorced If Yes, Give Year 4 Widowed other than "natural", ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Old Navy Department College (1-4 or 5+) Elementary/Secondary (0-12) Stores Sales Clerk MD 21215-0036 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Felicia Ann Shorter Tyrone McCoy Dixon Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Mother) 2 14542 London Lane; Bowie, Maryland 20715 Felicia Shorter Dixon Reid Date 20c. Location - City or Town, State 20b Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Pages 1 a X Burial 2 Cremation 3 Removal from State Washington, D.C. Mount Olivet Cemetery Nov. 10, 2006 permit. Page: Department o Important: Donation 5 Other Specify 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc.
600 Kennedy Street, N.W.; Washington, D.C. 21 Signatury of Funer ice License 20011 Xuna Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death /Medical a Gunshot Wound to Right Thigh Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and ca AMENDED tending physician a UNPENDED Physician/Medi Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I o 1 Yes 2 V No 3 Probably 4 Unknown à ٦ Completed Division of Vital Records, 24b Were autopsy findings available 24a. Was an has been s prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 page certificate 26. Place of Death (Check only one) After this certific funeral director, p 25. Was case referred to medical Hospital or Attending Physician: Be examiner? Residence 6 Other DOA Nursing Home 5 Inpatient 2 V ER/Outpatient 3 1 🗸 Yes ဥ No 28d Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Nov 2, 2006 28b. Time of Injury Manner of Death Subject shot Certification: 2308 hrs 1 Yes 2 V No Natural Director: / Pending 24 hours after death. Funeral Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by 3 Could not be or Town, State) 14542 London Lane, Bowie, MD Suicide determined (Specify) Single Family 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 2 To the I one) and manner stated 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier November 3, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner Registrar's Signature State Registra

DHMH 17 Rev 1/2001 OCME 2006 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 37672 For State Registra/Prend#7. PerFH PCC 11-14-06cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day DAVIS FRANK 825 AM 08 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL MONTOMERY TAKOMA 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1(XM 2□F

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel; or Items 23a or 28a-f show any lajury or other traumatic event, Ita Madical Examplest must be inclified at once.

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

| Isual Residence of Decedent | | | | | 114 North Carol |
|---|--|---|--|--|---|
| 0a. State 10b. County | 10c. City | , Town or Location | | | 10d. Inside City L |
| Md Montgome | ery Hyat | tsville | | | 1 (XYes 2 |
| 0e. Street and Number | | 10f. Zip | Code | 10g. | Citizen of What Country? |
| 500 Riggs Road | | 20 | 783 | US | A |
| 1. Marital Status | Was Decedent Ever in U. Armed Forces? | S. 13. Was Deced | dent of Hispanic Origin? (S offy Cuban, Mexican, Puerl | pecify Yes or No- o Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
| 1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced | 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: | 1 🗆 Yes | 2☑ No Specify: | | SpecifyBlack |
| 15. Decedent's Edu (Specify only highest grad | | 16a. Decedent's Usua (Give kind of wo life. DO NOT u | rk done during most of wor | king 16b. | . Kind of Business/Industry |
| 9th | College (1-4or 5+) | Long Sho | • | Pr | ivate Industry |
| 7. Father's Name (First, Middle, Last) | | - | | ne (First, Middle, Maid | len Sumame) |
| Allen Dav | is | | Ali | ce Overt | on |
| 19a. Informant's Name/Relationship (T) | pe, Print) | | | | y or Town, State, Zip Code) |
| !0a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ F | Iamoval from State | lace of Disposition (Naremetery, crematory or co | ther place) | Date 20c. | Location · City or Town, State Verdale Marylar |
| 4 □Donation 5 □ Other (Specify) | | 1 | nd Address of Facility | .0,00 KI | DC 200 |
| 14.0C1 | mune | 10 | , | 719 Kenn | edy St. NW Was |
| 23a. Part1. Enjer the disease, or compl | . 0,000 | | | | Approximate |
| 23a. Part1. Enfer the disease, or confol shock of heart failure. List only of mmediate Cause (Final disease or condition | | | CARDIOVA. | | Interval Betwee Onset and Deal |
| esulting in death) | Due to (or as a consequ | | 011-11004. | 300770 | Mar |
| aguentially list ou ditions, any, leading to immediate | Due to (or as a consequ | uence of): | | | |
| cause. Enter Underlying Cause (Disease or injury hat initiated events | | | | | |
| resulting in death) Last | Due to (or as a consequ | uence of): | | | |
| | 1 | | | | |
| F FEMALE: | | | | | |
| 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown | death 3 Ectopic pr | | | 23d. Date of delivery Month Day Year |
| art II. Other significant conditions co | ntributing to death but not res | ulting in the underlying o | ause given in Part I. | 23e. Did tobacc | o use contribute to the cause of death |
| | | | • | 1 🗀 Yes | 2 No 3 Probably 4 Links |
| | | | | 24a. Was an | 24h Ware autoney findings avan |
| | | | | autopsy performed | 24b. Were autopsy findings available prior to completion of cause death? |
| | | | | | |
| E. Was associated to marked | | | | 1 □ Yes 2/5 | No 1 ☐ Yes 2 No. |
| examiner? | lospital: | | Other | ath (Check only one) | evel- |
| examiner? YGYes 2 No 7. Manner of Death 1 Natural 5 Pending | Hospital: 1 Inpatient 2 A | | OA Other: 4 Nursing H | | 6 □Other (Specify) |
| examiner? 10 Yes 2 No 7. Manner of Death | 28a. Date of Injury | 28b. Time of Injury M | OA Cther: 4 Nursing H | ath (Check only one) lome 5 Residence 28d. Describe how in | 6 □Other (Specify) ijury occurred and Number or Rural Route Number, |
| examiner? 27. Manner of Death 1 | 28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At he building, etc. (Specify | 28b. Time of Injury M ome, farm, street, factory wledge, death occurred | OA Other: 4 Nursing Helse. Injury at Work? 1 Yes 2 No | ath (Check only one) lome 5 Residence 28d. Describe how in 28f. Location (Street City or Town, St. | 6 □Other (Specify) njury occurred and Number or Rural Route Number, ate) |
| 27. Manner of Death 1 | 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specify sician: To the best of my kno- ner: On the basis of examinal | 28b. Time of Injury M ome, farm, street, factory wledge, death occurred tion and/or investigation | OA Other: 4 Nursing Head Nursin | ath (Check only one) lome 5 Residence 28d. Describe how in 28f. Location (Street City or Town, St. and due to the cause ured at the time, date a | 6 □Other (Specify) njury occurred and Number or Rural Route Number, ate) n(s) and manner as stated, and place, and due to the cause(s) Date signed (Month, Day, Year) |
| examiner? | 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specify sician: To the best of my kno- ner: On the basis of examinal | 28b. Time of Injury M ome, farm, street, factory wledge, death occurred tion and/or investigation | OA Other: 4 Nursing Head Nursin | ath (Check only one) lome 5 Residence 28d. Describe how in 28f. Location (Street City or Town, St. and due to the cause ured at the time, date a | 6 Other (Specify) injury occurred and Number or Rural Route Number, ate) i(s) and manner as stated, and place, and due to the cause(s) |

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 4 2006

| | | | 1 - For State Registrar | State of Maryla | | | | nd Mental F | Reg. No. | 06 | 37673 | |
|--|---|-----------------|---|--|--|--|--|---|--|--|---|--|
| | Physic /Medi | cal | 1. Decedent's Name (First, Middle, Last) 4b. City, Town, or Location of Death | | | | | | 2. Date of Death Month Day Year 3. Time of D | | | |
| | Examii Funeral Director | P | 5. Social Security Number 6. 219-88-7375 | HOSPITAL | | 4b. City, Town, or Location of Death If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | | 4 Hrs. 8. Date of Min. (Month. | 8. Date of Birth (Month, Day, Year) Oct. 17, 1924 | | y of Death 9. Birthplace (State or Foreign Country) Haiti | |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. Important: If tem 27 is marked other than "natural", or itsms 23s or 28s-f show sny injury or other traumatic event, its Madical Evantine must be notified at once. | | Usual Residence of Decedent 10a. State 10b. County Maryland Montgome 10e. Street and Number 6044 Rossmore Dr. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gir | 2 LY B 12. Was Decedent Ever in Armed Forces? 1 | 16a. Dece | 10f. Zip Co 20 Was Deceden If Yes, specify 1 Yes 25 | 814 t of Hispanic Origi Cuban, Mexican, I No Specity: | n? (Specify Yes or Puerto Rican, etc.) of working | 10g. Citizen of V U.S.A. No- 14. Rac Blac Specify 16b. Kind of Bu | Vhat Country e - American k, White, etc | Inside City Limits PE Yes 2 □ No ? Indian, | |
| | | To Be Comp | Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last Albert Etienne | | Civil | Engin | 18. Mother: | s Name (First, Midd | World H | Θ) | | |
| | | | Marie Etienne 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 ☐ 4 □ Donation 5 □ Other (Speci | Wife 20b. Removal from State Na | 6044 Place of Dispocemetery, cremational | Rossmo: sition (Name inatory or othe Crema: 2. Name and A | re Dr. Be | othesda, in Date v. 13, 06 Joseph G. | Maryland 20c. Location Falls Cawler's S | 20814 City or Town, hurch, ons, I | Va. | |
| Division of Vital Records, P.O. Box 68760, | thysician: The law requires the certificate hes been signed it director, page 2 should be considered. | Icai Examiner | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | |
| | | Physician/Med | FEMALE: 8b. Was decedent pregnant in the past 12 months? 1 | | | | | | | 23d. Date of delivery Month Day Year | | |
| | | Completed by Ph | The contribution of the cause of death? | | | | | | | | findings avaitable ation of cause of | |
| | | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 1 Yes 2 No | | | | | | | l No | |
| | | Certification: | 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined | 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, St | | | | | | | | |
| | | Medical | 29a. Certifier (Check only one) 29b. Signature and title of certifier (29c. License number 226. Date signed (Month, Day, Year) | | | | | | | | cause(s) | |
| | , • | | 30. Name and address of person who Dany Westerband M | | lle Pil | ke #G10 | 0 Rockvi | 11e, MD 2 | 0852 | , C(_C | > | |
| \$ | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 1 3 20 | 3 Registrar's Sign | ature | de | | | | | | |

6 PM

1116106

Gerard Etienne

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 3, 2006 Vincenza Carmela Epling (aka Virginia Epling) Nov. 12:00 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Specialty Hospital Baltimore Baltimore If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 X F 218-16-0161 82 Director 8/31/1924 Seabrook, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 ie marked other than "natural", or tems 23a or 28a-f aho treumstic event, the Madical Examinar must be notified at Prince George's Maryland Riverdale Park 12 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5910 Taylor Road 21230 USA Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White ፩ 3 ☐ Widowed 4 ₺ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Labor Union permit. Pages 1 and 2 should be fill Department of Health and Mentel H Important: If Item 27 ie marked othen eny Injury or other treumatic eventer. 8 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Cipriano Carmilla Rosso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis J. Cipriano - Daughter 7306 Shady Glen Dr., Columbia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Resurrection Cemetery 4 ☐ Donation | 5 ☐ Other (Specify) 11/10/06 Clinton, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Ave., Hyattsville, MD 20781 23a/ Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) **V**Sepsis Examiner Due to (or es a consequence of): Examiner Pneumonia or Attending Physician: The law requires that the death certificate be associted after death.

Director: After this certificate has been signed by the attending physician and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Acute and chronic renal failure Physician/Medical Due to (or as a consequence of): Respiratory failure, ventilator dependent Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Congestive heart failure Š Completed 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Diabetes mellitus 1 ☐ Yes 24 ☑ No 1 ☐ Yes 2 ☐ No of Vitai å 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide edical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the ceuse(s) and manner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 00050480 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZERA-YOHANNES, 601 South Charles St, Baltimore, MD21230 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

NOV 1 3 2006

Registrar DHMH 17 Rev 1/2001

State

State of Maryland / Department of Health and Mental Hygiene 0 6 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 06 2006 OLIVER FISHER /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) PENINSULA IONAL Medical Center Wiconico 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Yrs. Director 74 SEP 20,1932 GUMBORO, DE 221-20-4848 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 27 is marked other then "neturel", or items 23e or 28e-f ehow treumstic event, the Micilian Examinar must be notified at 10d. Inside City Limits Director 1 Yes 2 No DELAWARE SUSSEX COUNTY **MILLSBORO** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29254 REVEL ROAD 19966 UNITED STATES Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Š Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) POULTRY FARMER AGRICULTURE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be n and Mental OLIVER J. FISHER HELEN F. TINGLE ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Depertment of Heelth a Important: if item 27 is eny injury or other trea once. MARJORIE ANN FISHER (SPOUSE) 29254 REVEL RD., MILLSBORO, DE 19966 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State MILLSBORO CEMETERY NOV.12,2006 MILLSBORO, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Pacifity
WATSON FUNERAL HOME MO1361 MILLSBORO, DELAWARE 19966 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Spontanea **Physician** intravious disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760, Physician/Medical fF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f o. 9 Unknown 9 Unknown ۵ s been signed by should be deta Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à HTW Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to compfetion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate 1 ☐ Yes Vital 2 100 Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ð After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending within 24 hours efter death.

To the Funerel Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifi 29d. Date signed (Month, Dey, Year) H50497 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 6 SNYDER 51. D.O. 100 E. CAKKOII 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 13 2006 NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2006 Michael Fontana November 8, 8:13 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Olney Montgomery General Hospital Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min 1 JM 2 □ F Director 26, 1926 Washington, DC 79 579**-**26-4753 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show the Medical Exactinar must be notified at 1 Yes 2 No Funeral Director Maryland Montgomery Wheaton 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 238 20906 3308 Janet Road USA death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, or iteme Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 Divorced WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) I Hygiene. College (1-4or 5+) Lithographer Printing of Health and Mental Hygie fitem 27 te marked other ir other treumatic event, III Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Umberto Fontana Elena LeDonne ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Fontana/ Wife 3308 Janet Road, Wheaton, Maryland 20906 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Peges permit. Peges Department of Important; if it any injury or o ō November 13 1 □ Burial 2 □ Cremation 3 □ Removal from State entombment Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 2006 Silver Spring, Maryland Francis Advess Collins Funeral Home Inc. 21. Signatur of Huneral Service Licenses Colly Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial /Medical Due to or as a consequence of): Examiner oschero. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ettending physicien for use as the buria Physician/Medical BOX23A (A) Clepen Joyce + FH Rep / Brum Division of Vital Records, P.O. Box 687 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 2 No 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ne 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 1 Contifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) Med Der MGH 29c. License number 0050410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prone Ph.l.s Dr. Olney MD 18101 MA chac 31. Date fited (Month, Day, Year) pegistrar's Signature 32. State 13 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Ralph Frenke1 2006 November 12:39 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alfred House Elder Care Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ₩ 2 □ F Months 92 Poland 085-24-4865 March 3, 1914 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rral", or items 23a or 28a-f show I Examiner must be notified at 1X Yes 2 □ No None Washington Director D. C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be none. 20016 3101 New Mexico Avenue, N. W., # 1002 U. S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify None Completed by 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Apartment Elementary/Secondary (0-12) College (1-4or 5+) Property Maintenance Supervisor Complexes 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Unknown) Frenkel (Unknown) P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zip Code) 3101 New Mexico Avenue, N. W., # 1002 Helen Feinbloom - Daughter Washington, D. C. 20016 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 X Removal from State 11/9/2006 Falls Church, Virginia National Crematory 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction,
1091 Rockville Pike, Rockville, 21. Signature of Funeral Service Licensee Inc. Maryland 20852 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Weeks Immediate Cause (Final **Physician** Conrestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Weeks Examiner Coronary Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of) Examine Months spital or Attending Physician: The law requires that the death certificate be executed ours after death.

Peral Director: After this certificate has been signed by the attending physician and "illed in by the funneral director, page 2 should be detached for use as the burial-transit Cardiovascular Disease Due to (or as a consequence of): Box 68760 Months Generalized Arteriosclerosis Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Azothemia, Chronic Obstructive Lung Disease 1 Yes 2 No 3 Probably 4 Unknown Completed Alzheimers Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5XI Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 1 3 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Oliver J. Lawless, M. D. 18111 Prince Philip Drive, Olney, Maryland

Registrar's Signature

29c. License number

D 25410

29d. Date signed (Month, Day, Year) November 7, 2006

State

Registrar

31. Date filed (Month, Day,

Year

NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Phyllis Taylor Glaude 8:58 PM 6, 2006 Nov. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 409 East Indian Spring Drive If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 25 F 76 Yrs. 115-24-7039 07-29-1930 Director Wash., D.C. Usuat Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Director Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 20901 USA 409 East Indian Spring Drive Items 23c Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☐ No Specify: Black þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) D.C. Public Schools Librarian injury or other treumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If tiem 27 Is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Young Harvey U. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 East Indian Spring Drive William Glaude (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Naryland
Date 20901 20c. Location - City or Town, State 20a. Method of Disposition 11√2 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD. Lincoln Memorial 11-13-06 21. Signature of Funeral Service Liten e Ralph Williams Funeral Service 1813 Potomac Ave., SE; Wash., DC Ralph Williams Funeral State 1813 Potomac Ave., SE; Water 1813 Potomac Ave., SE; Water 1813 Potomac Ave., SE; Water 1813 Potomac Ave., SE; Water 1814 Potomac Ave., Se; Water 1815 Potomac Ave., Se; Water 1815 Potomac Ave., Se; Water 1816 Potomac Ave 20003 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Squamous Cell Cancer Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): use as the burialattending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Arteriosclerotic Cardiovascular Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 😾 No To the Hospitel or Attending Physician: 25. Was case referred to medicat examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 ▼No 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death nerel Director: / filled in by the f 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical (Check only he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29c. Licanse number 29b. Signature and time of certifier 29d. Date signed (Month, Day, Year) 08 November 7, 2006 سمالا 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20832

DHMH 17 Rev 1/2001

State

Registrar

Benjamin

Avrunin, MD

2006

Year)

9

18111 Prince Philip Dr., Ste. 209 Olney, MD.

| | | For State Registrar | | State o | f Maryla | | partmen ertificat | | | | fental Hyg | giene | 06 | 376 | 581 |
|--|----------------|--|---|--|--|-----------------------------|----------------------------------|-----------------------------|----------------------|-----------------------|---|--------------------------------|-------------------------|--|--------------------|
| Physici | an | | ne (First, Middle, Last) | | CORROY | | | | | | 2. Date of Dea Month | Day | Year | 3. Time | 14 |
| /Medio Examin | | JULES 4a. Facility Name (| L. (If not institution, give: | street and nur | GORDON mber) | | 4b. City, | Town, or | Location | of Death | NOVEMBER | | nty of Deat | 9:17 | A M |
| Examin | | 11500 DANV | VILLE DRIVE | | | | ROCKV | | | | | | OMERY | | |
| Funeral Director | | 5. Social Security 1 579-60-689 | 95 ¹ [Ş | M 2□F | 7. Age (In yrs | i. last birthd 2 Yrs | Months | | If Under Hours | 24 Hrs. Min. | 8. Date of Birth (Month, Day APRIL 4, | (, Year) | Co | hplace (State untry) INGTON, | |
| rland ow | | Usual Residence of 10a. State | 10b. County | | 10c. C | ity, Town o | Location | | | | | | | 10d. Inside (| City Limits |
| a-f eh | ctor | MARYLAND | MONTGOMERY | | ROCE | KVILLE | | | | | | | | 1 ☐ Ye | s 2 No |
| vith th | Director | 10e. Street and Nu | umber | | | | 10f. Zip | Code | | | | 10g. Citizen | of What Co | untry? | |
| eath v | eral | | /ILLE DRIVE | 12 Was Door | edant Consist | 11.0 | | 208 | | 0.10 | | U.S | | | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neture!; or Items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinat must be notified at one. | by Funeral | | rried 2 Married | Armed Fo 1 Yes If Yes, Giv Year or Da | 2 [X]No ∕e | 0.5. | If Yes, spec | 100 | n, Mexicar Specify: | | ecify Yes or No- Rican, etc.) | Spe | llack, White | rican Indian, e, etc. HITE | |
| 72 ho | eted | (Spe | 15. Decedent's Edu | | | 16a. De | cedent's Usu | al Occupa | ation | t of work | una . | 16b. Kind of | | | |
| within ne. hen " | Completed | Elementary/Sec | | College (1 | -4or 5+) | Int | e. DO NOT u | se retired |) | i ui wur | mg . | 200.00 | | | |
| filed v Hygie other t | e Co | 17. Father's Name | (First, Middle, Last) | 4 | | OWNE | K | | 18 Mothe | ar's Nam | e (First, Middle, | RETAIL | | | |
| lid be lental rked o | To Be | SAMUEL | , | GORD | ON | | | | LILY | J. 3 114 | o (i ii si, iviidalo, | WERBER | amej | | |
| shou and M s mar | - | 19a. Informant's N | Name/Relationship (Ty | | | 19b. M | ailing Address | (Street a | | er or Rur | al Route Numbe | | m, State, Z | ip Code) | |
| and 2 ealth m 27 i | | | GORDON/WIFE | | | | | | IVE, F | ROCKV | ILLE, MARY | LAND 20 | 852 | | |
| if ite | | 20a. Method of Dis 1 XBurial 2 | sposition 2. □Cremation 3. □XP | emoval from : | State | cemetery, o | sposition (Nar crematory or o | ther place | · 1 | | Date | 20c. Locatio | n - City or 1 | Town, State | |
| utmen utent: injury | | | 5 ☐ Other (Specify) uneral Service Licens | | KI | NG DAVI | D MEMOR | | | - | /2006 | FALLS (| CHURCH, | VIRGIN | IA |
| Depa Impo eny i | | 21. Signatur or Fi | anda - | Rudo | 1170 | . | 22. Name ar HINES-RI | NALDI | FUNER | AL HO | OME, INC. NUE, SILVE | D CDDTI | | | |
| Physician /Medical Examiner | | Immediate Cause disease or condition resulting in death) Sequentially list co | onditions. | CEREBR Due to (| OVASCULA or as a conse | AR ACCI | | e of dying | J, such as | cardiac | or respiratory arr | est, | | Approxima Interval Be Onset and 1-5 YEA | etween Death |
| icate be executed physicien and s the burial-transit | dicai Examiner | it any, reading to a cause. Enter Und Cause (Disease or that initiated event resulting in death) | mmediate lerlying r injury ts | | or as a conse | | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours eltar death. To the Funeral Director: Affer this certificate has been signed by the attanding physicompletely filled in by the funeral director, page 2 should be detached for use as the | Physician/Med | IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown | 2 months? | 1 Live b | come of pregrinth 2 Fet ant at time of own | al death | 3 □Ectopic pr 5 □ Other (sp | | | | | | Date of delin | - | Year |
| quires that n signed b uld be det | É | | ificant conditions con | | | sulting in the | e underlying c | ause give | n in Part I. | | | bacco use co es 2 □ No | | the cause of | |
| The law rev te hes bee ege 2 shor | Completed | | | | | | | | | | 24a. Was a autops perform | ned? | prior to co death? | opsy findings | available cause of |
| itan: rtifica ctor. p | BeC | 25. Was case reference | rred to medical | | | | | | 26. Place | of Deat | 1 Yes : | | 1 ☐ Yes | 2∐ No | |
| hysic his ce | To | 1 Yes 2 2 | &No H | | |] ER/Outpa | tient 3 DC | Othe | - | | me 5 🖾 Reside | | ther (Spec | ify) | |
| tending P leath. tor: After t the funera | Certification: | 27. Manner of Dea: 1 XNatural 2 Accident 3 Suicide | th 5 ☐ Pending investigation 6 ☐ Could not be | 28a. Date of | of Injury h, Day Year) | 28b. Time Injur | of 2 y M | 8c. Injury Work 1 🔲 Y | at ? ′es 2 □ l | - | 28d. Describe ho | ow injury occ | urred | | |
| oital or Al urs eftar c eral Direc | | 4 Homicide | determined | buildir | of Injury - At h | ify) | | | | | 28f. Location (St City or Town | n, State) | | | nber, |
| the Hosp nin 24 ho the Fune npletely f | Medicai | 29a. Certifier (Check only one) | 1 ☑ Certifying Phys 2 ☐ Medical Examir | ician: To the ler: On the ba and mann | asis of examin | owledge, de ation and/or | investigation, | in my op | inion, dea | d place, th occurr | and due to the cared at the time, d | ause(s) and a ate and place | manner as e, and due | stated. to the cause(| s) |
| or To Con | ~ | 29b. Signature and | d tute of certifier | 1.11 | 12 | | | License | | 2 | . 2 | 9d. Date sigi | ned (Month) | Day, Year) | |
| 10 | | 20 Name and add | July J | wee | ~ | - 05:1 - | | 115 | 818 | | N | OVEMBER | 8, 20 | 06 | |
| - | | | tress of person who co ER, M.D., 553 | | | | | CHEV | Y CHAS | SE. M | ARYLAND 20 | 815 | | | |
| Sta | | 31. Date filed (Mor | nth, Day, Year) | 32,70 | egistrar's Sign | ature | | , 51111 | . 01111 | 0 11 | 20 | | | | |
| Registra | ar | | VOV 13 20 | 06 | BARA A | B. A | marke | | | | | | | | |

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

| | | | For State Registrar | State o | f Man | yland / Depa <i>Cer</i> | irtment of I tificate of | | | giene Reg. No. | 006 | 37682 |
|---------------------------------|--|-------------------------------|---|---------------------------------------|---------------------------|--|--|--|--|-------------------------------|-------------------------------------|---------------------------------|
| | Diam'r. | | 1. Decedent's Name (First, Middle, Las | t) | | | | | 2. Date of De Month | ath Day | Year | 3. Time of Death |
| | Physicia /Medic | | Ceceli | a E. | _Gre | een | | | Novembe | er 8. | 2006 | 8:19P M |
| | Examin | er | 4a. Facility Name (If not institution, give Prince George's H | street and nur lospita. | | | 4b. City, Town, Chever | or Location of Death Ly | | | | orge's |
| | Funeral Director | | 5. Social Security Number 6. Security Number 1 | ex □M 2∏7 F | 7. Age (/ 89 | n yrs. last birthday) Yrs. | If Under 1 Year Months Days | | 8. Date of Bir (Month, Da 10/23/ | th ay, Yeer) 1917 | | place (State or Foreign ntry) |
| | p | | Usual Residenca of Decedent | | 1 | Oc. City, Town or Lo | | | | | | 10d. Inside City Limits |
| | arylar ehow | 5 | 10a. State 10b. County Maryland Prince G | enrae's | | Forestvil | | | | | | 1 ☐ Yes 2 X No |
| | the M | ecto | 10e. Street and Number | | | - 01 00 0 1 12 | 10f. Zip Code | | | 10g. Citizen | of What Cou | intry? |
| | with Se or | ٥ | 2805 Quay Ave. | | | | 20747 | | | USA | | , |
| | Jeath The 23 | era | 11. Marital Status | 12. Was Dece | edent Eve | er in U.S. 13. \ | | Hispanic Origin? (Span, Mexican, Puert | pecify Yes or No | | Race - Amer | |
| 336 | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neture!; or items 23e or 28e-f ehow aumatic event, the Medical Examinar must be notified at | Completed by Funeral Director | 1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced | Armed For 1 Yes If Yes, Gir Year or D | 2∭∑No ve | | f Yes, specify Cub 1 ☐ Yes 21X No | | o Hican, etc.) | i | Black, White ec <i>ity:</i> Whit | |
| Ö o | 72 ho | ted | 15. Decedent's Ed (Specify only highest gra | lucation de completed) | | 16a. Deced | lent's Usual Occu | pation during most of wor | kına | 16b. Kind | of Business/li | ndustry |
| 2 | ithin i | nple | Elementary/Secondary (0-12) | College (| 1-4or 5+) | life. I | DO NOT use retire | ed) | • | 0 | • | |
| 2 | led w lygier lygier her th | ပိ | 11th 17. Father's Name (First, Middle, Last) | | | Homem | aker | 18. Mother's Nan | ne /First Middle | Own I | | |
| Maryland 21215-0036 | od be fi | Be | Fred Elonza God | | | | | Margueri | | | | lt |
| Ž | should id Me mark matic | ၉ | 19a. Informant's Name/Relationship (1 | | | 19b. Mailir | ng Address (Stree | t and Number or Ru | | | | |
| <u>S</u> | nd 2 salth ar | | Alice C. green - | | er | 7306 | Malden L | n.,Forest | ville, | MD 207 | 47 | |
| Baltimore, | permit. Pages 1 and 2 should be Department of Health and Menta Importent: if item 27 is marked eny injury or other traumatic ev QDEs. | | 20a. Method of Disposition 1 Disposition 2 Cremation 3 4 Donation 5 Other (Specify | | State | 20b. Place of Dispo cemetery, cren Resurrect | natory or other pla | | Date 13/06 | | ion - City or T | |
| Baltii | Depermit. F Depertme Importer eny injur | | 21. Signature de neral Service Licen | | | 22 | . Name and Addr | ess of Facility Geo | orge P. | Kalas | Funera | al Home |
| | | | 23a. Part 1 Enter the disease, or come shock or heart failure. List only | ofications that | caused th | | | | | | | Approximate Intervat Between |
| | Physician | 0 1 | Immediate Cause (Final disease or condition | a. FATA | L (| ARDIAC | ARRHYT | THMIA | | | | Onset and Death |
| ı | /Medical Examiner | | resulting in death) | CONG | (or as a c | CARDIAC consequence of): VE HEAP consequence of): LUNG | RT FAIL | URE | | | | |
| | gi. g | Iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to | (or as a c | consequence of): | DISFAS | | | | | |
| | and I-trans | Examiner | that initiated events resulting in death) Last | c. Due to | (or as a c | consequence of); | 210040 | | | | | |
| 8760, | icate be executed physicien and s the burial-transit | dical E | | HYPE | RTE | ENSION | | | | | | |
| 687 | ificate g phys | 4 | | 0. | | | | | | | | |
| Вох | Attending Physician: The lew requires that the death certificate be executed rideath. sctor: Atter this certificate has been signed by the attending physicien and etor: Atter this certificate as been signed by the tuneral director, page 2 should be detached for use as the burial-transit | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | | birth 2 nant at tin | Fetat death 3 | Ectopic pregnand Other (specify) | су | | 23d | l. Date of deli Month | very Day Year |
| Division of Vital Records, P.O. | ires that the de signed by the a d be detached f | | Part II. Other significant conditions of DIABETES | ontributing to d | eath but | not resulting in the u | nderlying cause g | iven in Part I. | | tobacco use | | the cause of death? |
| Ö | w require been si should b | lete | | | | | | | 24a, Was | s an 2 | 4b. Were aut | opsy findings avaitable |
| Re | ician: The lev certificete has rector, page 2 | Completed by | | | | | | | auto | opsy ormed? | prior to o death? | ompletion of cause of |
| ta | inficetor, pe | Be Co | 25. Was case referred to medical | | | | | 26. Place of Dea | 1 ☐ Yes | 2X No | T Yes | 2□ No |
| ≥ | ysici is cer direct | To B | examiner? 1 ☐ Yes 2)⊠ No | Hospital: 1 | Inpatient | 2 ER/Outpatier | nt 3 DOA | har | lome 5 ☐ Res | | Other (Spec | ıfy) |
| o uo | iding Ph th. After th funeral | tlon: | 27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident investigation | | of Injury oth, Day Y | 28b. Time o Injury | W | uryat ork?]Yes 2∐No | 28d. Describe | how injury o | ccurred | |
| Divisi | 5 4 5 5 | Certification: | 3 Suicide 6 Could not b 4 Homicide determined | 28e. Place | e of Injury ling, etc. | y - At home, farm, str (Specify) | reet, factory, office |) | | (Street and Nown, State) | lumber or Ru | ral Route Number, |
| | Hospita 24 hours Funerel tely filled | Medical C | 29a Certifying Ph (Check only 2 Medical Example) | niner: On the b | e beet of pasis of e | my krowledge, deat xamination and/or in id. | h consumed at the livestigation, in my | time date and place opinion, death occu | and due to the cred at the time. | cause(s) an , date and pla | d manner as ace, and due | stated to the cause(s) |
| | To the within 2 To the comple | Me | 29b. Signature and title of certifier | 25 | ha | | | 60339 | | | igned (Month | |
| R | (10) | | 30 Name and address of person who | completed cau | e of dea | 3001 Hos | Print) | De | CHEVE | ERLY, N | 1D 2 | 0185 |
| | Sta | ate | 31. Date filed (Month, Day, Year) | 32. | Registrar' | 3001 Hos s Signature | <i>J</i> , | | | | | |
| | Regist | rar | NOV 1 3 2006 | Dave | L . | D. Open | | | | | | |

| | | | 1 - For State Registrar | State of Maryl | | | of Health a of Death | and Mer | | giene Reg. Na | 2006 | 37683 |
|---------------------|--|-------------------|---|---|------------------------------------|--|--|--|---------------------------------------|--------------------|--|--|
| | Physicia /Medic | al | | ernande | 3 | | | N | Date of Dea Month | Day | Zoole | 3. Time of Death |
| | Examin Funeral Director | - | 4a. Facility Name (If not institution, given Shady Grove Hospi 5. Social Security Number 6. State 103-22-6566 | tal | yrs. last birthday) Yrs. | Rockv | | 24 Hrs. 8 | Date of Birt (Month, Day 14-19 | Me | | y lace (State or Foreign try) Rico |
| | | tor | Usual Residence of Decedent | | City, Town or Li | | age | | | | 1 | 0d. Inside City Limits 1X Yes 2 □ No |
| | th with the 23a or 284 | Funeral Director | 10e. Street and Number 20100 Rothbury La | ne Unit 3103 | | 10f. Zip Co | 6 | | | U.S. | | |
| 980 | ours after dea rai', or items Exeminant | by | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. Was Decedent Ever Armed Forces? 1 ∑Yes 2 ☐ No Thing If Yes, Give Year or Dates: | in U.S. 13. | Was Deceden If Yes, specify 1X Yes 2 | t of Hispanic Ori Cuban, Mexicar No Specify: | gin? (Specif n, Puerto Ric Puert | | n | 4. Race - Americ Black, White, His Specify: | |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hyglane. Important: If Item 27 is marked other than "natural, or Items 23e or 28e-f show supprignt; If Item 27 is marked other than "natural, or Items 23e or 28e-f show any Injury or other traumatic event, the Medical Examinar must be notified at ance. | Completed | 15. Decedent's E (Specify only highest gr. Elementary/Secondary (0·12) 12th | ducation ade completed) Cotlege (1-4or 5+) | 16a. Dece (Give ijfe. Pos | edent's Usual C kind of work of DO NOT use in STAL WO | occupation done during mos etired) TKCT | t of working | | | od of Business/In | • |
| /land | uld be filed Mental Hyg Irked othe Itic event, | To Be C | 17. Father's Name (First, Middle, Last Secundino Herna | | | | | er's Name <i>(F</i> jandri | | | Surname) | |
| , Mary | and 2 sho saith and ! n 27 is ma | | 19a. Informant's Name/Relationship (Elba Brenner- Da | ughter | 1900 | 8 Cape | Hart Dri | ive Mo | ntgome | ery V | | MD 20886 |
| Baltimore, | Pages 1 ment of H ant: If Ital jury or oth | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Special | Removal from State fy) | National | matory or other. Crema | tory | Date | 06 | Fall | cation - City or To Ls Churc | h, VA |
| Balt | Dermit Depart Import eny In | | 21. Signature o Funeral Service Lice | | 1 | .091 Ro | ckville | Pike | Rockv | ille. | , MD 208 | Direction 52 Approximate |
| | Fnysician /Medical Examiner | | 23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. | aDue to (or as a col | nsequence of): | iter the mode o | r dying, such as | cardiac of n | espiratory ar | rest, | | Interval Between Onset and Death 5 ACCUS |
| 8760, | death certificate be executed e ettending physicien and kd for use as the burial-transit | ilcal Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | C. Due to (or as a conduction of the conduction | | | | | | | | |
| .O. Box 6 | death certifi e ettending id for use as | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pr 1 □Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown | Fetal death 3 | □Ectopic preg □ Other (spec | | 45.7 | | 2 | 3d. Date of delive Month | ery Day Year |
| <u>a</u> | ires tha signed d be de | þ | Part II. Other significant conditions | contributing to death but no | t resulting in the | underlying cau | se given in Part I | l. | | obacco u Yes 2[| | he cause of death? |
| Il Records, | | Completed | | | | | | | 24a. Was autor perio 1 ☐ Yes | | prior to co death? | psy findings available impletion of cause of |
| Vital | Physicien: 1 this certifical ral director, p | o Be | 25. Was case referred to medical examiner? 1 Yes No | Hospital: Hopatient | 2 ☐ ER/Outpatie | ent 3 DOA | Other | e of Death (C ursing Home | | | i □Other (Specia | (v) |
| of | ding h. After fune | - | 27. Manner of Death Tanatural 5 Pending 2 Accident investigator | 28a. Date of Injury (Month, Day Ye | 28b. Time | | Injury at Work? | 280 | d. Describe I | | | ,, |
| Division | 호흡흡드 | Certification: | 3 Suicide 6 Could not determined | | | treet, factory, o | office | 281 | . Location (: City or To | | | al Route Number, |
| | o the Hoepital ithin 24 hours o the Funeral I | edical | | hysician: To the best of more miner: On the basis of exa and manner stated. | | | | | | | | |
| 200 | To the To the Comp | Z | 29b. Signature and title of certifier | 1 - | | 100 | icense number | | | 29d. Dat | e signed (Month, | Day, Year) |
| | 3 | | Blanki | USS MO | | | 06451 |)2 | | Noi | | 2006 |
| I | | ate rar | 30. Name and address of person who 31. Date filed (Month, Day, Yea) | o completed cause of death O C 32 Registrar's | 1 IVer | Print) | (en | r Driv | RE RE | ockvi | lle, mo | 20850 |

| | | | 1 - For Stete Registrar | State of I | Maryland / Dep <i>Ce</i> | artment rtificate | | | | ental Hy | giene Reg. No. | 2008 | 5 (| 37684 |
|----------------|--|----------------|--|---|--|----------------------|-----------------------------|--------------------------|-------------------------|----------------------------------|--------------------------|--------------------------|------------------------|--|
| | Physici | | 1. Decedent's Name (First, Middle, Las HELEN M. HAW | KINS | | | | | | 2. Date of Do Month NOVEMB | Day | 2006 | r | 3. Time of Death 5:04 P M |
| 7 | /Medic Examin | | 4a. Facility Name (If not institution, give | street and number | er) | 4b. City, 1 | Town, or | Location of | of Death | | | County of De | | |
| | | | MONTGOMERY GENERA | L HOSPIT | AL | OLNE | EY | | | | МО | NTGOME | ERY | |
| | Funeral | | 5. Social Security Number 6. S | 9X 7 □M 2 X F | Age (In yrs. last birthday | If Under Months | 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bi (Month, Di | nth ay, Year) | 9. E | Birthplace Country) | e (State or Foreign |
| | Director | | 577-16-6003 1 Usual Residence of Decedent | 2,81 | 92 Yrs. | | | | | Aug. 8 | 3 191 | 4 | Vir | ginia |
| | land | | 10a. State 10b. County | | 10c. City, Town or L | ocation | | | | | | | 10d. | Inside City Limits |
| | Mary H sh | į | Md. Montg | omery | Olney | | | | | | | | | 1 ☐ Yes 2 🗷 No |
| | r 28e | Director | 10e. Street and Number | | | 10f. Zip | Code | | | | 10g. Citiz | en of What | Country | ? |
| | 23a c | aiD | 18416 Georgia | Avenue | | | | 2083 | 2 | | Un | ited S | State | es |
| | r dea | Funeral | 11. Marital Status | 12. Was Decede Armed Force | nt Ever in U.S. 13. | Was Deced | ent of Hi ify Cuba | spanic Ori n, Mexicar | igin? (Spe n, Puerto | cify Yes or N Rican, etc.) | 0- 1 | 4. Race - Ar Black, W | | |
| 36 | ours after death with the Marylan ral', or Nema 23a or 28e-f show Examiner must be notified at | by Fi | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 2 I If Yes, Give Year or Date | MNo | 1 Yes 2 | No No | Specify: | | | | Specify: | Whi | ite |
| 21215-0036 | 72 hours after death with the Maryland "natural", or Itema 23a or 28e-f show olds! Examinational Candilliad at | | 15. Decedent's Ed | | | dent's Usua | I Occupa | ation | | | 16b. Kir | d of Busine | ss/Indus | trv |
| 215 | c * 3 | plet | (Specify only highest gra | de completed) College (1-4d | life. | NOT us | k done d e retired | <i>luring</i> mos) | t of worki | ng | | | | , |
| 21 | D 0 = | Completed | 12 | 1 | | Bank T | e11e | er | | |] | Bankin | g | |
| nd | be filed ital Hygie d other avent. | Be (| 17. Father's Name (First, Middle, Last) | | | | | 18. Mothe | er's Name | (First, Middle | , Maiden . | Sumame) | | |
| <u>yla</u> | | ု | | acken | | | | | isy | Brads | | | | |
| Maryland | allth a | | 19a. Informant's Name/Relationship (1 Sandra L. Ryan | | | _ | | | | Route Numb | - | | | _{де)} 23113 |
| Baltimore, | 00- | | 20a. Method of Disposition | D | 20b. Place of Disp | osition (Nam | ne of ther place | θ) | D | ate | 20c. Loc | ation - City | or Town, | State |
| ΣĒ | Lr Fall | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | Salem | Cemet | ery | | 11/1 | 0/06 | Bro | ookevi | 11e, | Md. |
| Salt | permit. Depertrimports Imports any Injure. | | 21. Signature of Funeral Service Licen | see B | 1 2 | 2 Name and Murie | Addres 1 H. | s of Facilit Barl | ber E | unera1 | Home | 9 | | |
| _ | 70 ≥ € a | | mercief W. | Sas | lier | P. O. | Вс | x 503 | 38, I | aytons | ville | | | 882 |
| | Physician | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition | one cause on each | sed the death. Do not en I line. | | e of drying | g, such as | cardiac o | r respiratory a | irrest, | | Int Or | proximate terval Between hiset and Death 417243 |
| | /Medical Examiner | | resulting in death) | Due to (or | as a consequence of): | | | | | · | | | | |
| | pe tis | lner | Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or | as a consequence of | | | | | | | | | 11.2 |
| • | ate be executed hysicien and the burial-transit | Examiner | that initiated events resulting in death) Last | c. Due to (or | as a consequence of): | | | | | | _ | | - | |
| 8760, | cate be exe physicien a the burial- | calE | | d | | | | | | | | | | |
| 9 | rtificat ng phy as th | 8 | IS SELVAN E. | | | | | | | | | | | |
| Вох | eath certific ettending p | an/ | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcor 1 ☐ Live birth | 2 Fetal death 3 | ⊒Ectopic pre | | | | | 2 | 3d. Date of o | delivery Da | y Year |
| 0 | at the dea by the er tached for | Physician/M | 1 ☐ Yes 2 No 9 ☐ Unknown | 4□ Pregnant 9□ Unknowr | | Other (spe | 9crfy) | | | | | Wichian | Da | y roai |
| <u>a</u> | that hed by deta | ру Р | Part II. Other significant conditions o | ontributing to death | but not resulting in the | underlying ca | use give | en in Part I. | | 23e. Did | tobacco us | e contribute | to the c | ause of death? |
| rds | w requires been sign should be | | | | | | | | | 10 | Yes 2€ | 4No 3□ | Probabl | y 4 Unknown |
| Vital Records, | a 2 C | Completed | | | | | | | | 24a. Was | | prior t | o comple | findings available etion of cause of |
| E H | | Col | | | | | | | | 1 Tes | ormed? 2 ☑ No | death 1 🗆 Y | | ∄ No |
| Vita | Physician: 1 this certificel ral director, p: | Be | 25. Was case referred to medical examiner? | Hospital: | | | △ Othe | VC | | (Check only | | | | |
| o | | 2 | 1 ☐ Yes 2 🛣 No 27. Manner of Death | 1 L Inpa | | | | 4 🗀 140 | | ne 5 Res 28d. Describe | | | oecify) | |
| o | Attanding I r death. ector: After by the funer | ţ | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of In (Month, in | Day Year) Injury | м | Bc. Injury Work 1 🔲 \ | (?` ∕es 2 🔲 i | | .00. 2000.120 | | 00001100 | | |
| Division | or Attendi after death. Director: A d in by the fu | Certification: | 3 Suicide 6 Could not be determined | 288. Place of | Injury - At home, farm, st etc. (Specify) | reet, factory, | office | | 1 | 28f. Location (| Street and wn, State) | | Rural Ro | oute Number, |
| ۵ | oltal or urs afte rral Dire | | | | | | | | | | | | | |
| | To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b | Medical | 29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam | niner: On the basis and manner | | rvestigation, | in my op | oinion, dea | th occurre | ed at the time, | date and | place, and d | ue to the | e cause(s) |
| | To th within To th comp | ž | 29b. Signature and title of certifier | 11 | - | 29c. | License | number | | | 29d. Date | signed (Mo | nth, Day | ', Year) |
| | | | Eu 15 | 190 | 4 | | DU | 534 | 7 | | NOVE | 四月花 | 8, | 4006 |
| , | | | 30. Name and address of person who | completed cause of | of death (Item 23a) (Type | , Print) | | , | | | | | | |
| | | | 31. Date filed (Month, Day, Year) | , m 5 | of 40 PEN ON | ry Ro. | mo | con | MYS | VILLE | , m | ph/ | 029 | 2 |
| 4 | Sta Registr | | NOV 0 9 2 | 006 | of death (Item 23a) (Type | Bells. | | | | | | | · | |

| | | • | For State Registrar | State of Marylar | | artment of H rtificate of | | - | giene Reg. Na. 00 | 6 376 | 85 |
|---------------------------------|---|----------------|---|---|------------------------|--|---------------------|-------------------------------------|----------------------|---|---------------|
| | Bl i a i | | 1. Decedent's Name (First, Middle, Las | st) | | | | 2. Date of De | ath Day | 3. Time of | f Death |
| | Physici /Medic | | Margaret Ellen | Herron | | | | | ber 10, | 2006 9:30 | рм |
| | Examin | er | 4a. Facility Name (If not institution, give | street and number) | | 4b. City, Town, o | or Location of Deat | h | 4c. County | of Death | |
| | | | Montgomery General 5. Social Security Number 6. Se | | last hirthday) | Oli If Under 1 Year | ney If Under 24 Hrs | 8. Date of Birt | | tgomery 9. Birthplace (State of | or Foreign |
| | Funeral Director | | 166-16-6758 | □M 2☑F | 37 Yrs. | Months Days | Hours Min. | (Month, Da | y, Year) 7, 1919 | Pennsylva | |
| | land | | Usual Residence of Decedent 10a. State 10b. County | 10c. C | ity, Town or Lo | ocation | | · | | 10d. Inside C | city Limits |
| | Many 1 sho | to | Maryland Montgom | OTIZ (| Gaither | ahura | | | | 1 🗆 Yes | 2 ∑ No |
| | or 28e | Directo | 10e. Street and Number | | our cher | 10f. Zip Code | | | 10g. Citizen of W | | |
| | 23a c | | 35 Windbrooke C | ircle | | | 20879 | | | USA | |
| 36 | ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show or other treumatic event, the Medical Examine must be notified at | by Funeral | 11. Marital Slatus 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced | 12. Was Decedent Ever in t Armed Forces? 1 Tyes 25 No If Yes, Give Year or Dates: | | Was Decedent of H If Yes, specify Cub: 1 ☐ Yes 22 No | an, Mexican, Puer | pecify Yes or No to Rican, etc.) | Black | e - American Indian, k, White, etc. White | |
| 2-0036 | 2 hou | | 15. Decedent's Ed | lucation | 16a. Dece | dent's Usual Occup | pation | | 16b. Kind of Bu | siness/Industry | |
| 215 | hin 7. | Completed | (Specify only highest gra | College (1-4or 5+) | life. | kind of work done DO NOT use retire | during most of wo | | Montgome | ry County | |
| 2 | filed within Hygiene. other than " | Con | | 1 | Admin | istrativ | | | Public S | | |
| n D | be fill d oth | Be | 17. Falher's Name (First, Middle, Last) | | | | | | Maiden Sumam | а) | |
| <u> </u> | should nd Men s marks umatic | ^L | Thomas McAndrew 19a. Informant's Name/Relationship (| Tuna Printl | 10b Madi | ng Address (Street | ! | ilda Kel | | State Zin Code) | |
| Maryland 2121 | d 2 si th and t7 is r | | Mary Ellen Stagg | | | Campfire | | | | | |
| | Health tem 27 other ti | | 20a. Method of Disposition | 20b. | Place of Dispo | osition (Name of | | Date | 3. | City or Town, State | |
| 9 | Pages nent of P ant: If It ury or of | | 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify | Hemoval from State | | natory or other place eaven Cemete | ert/ | mber 14 006 | Silver S | pring, Mar | rul and |
| Baltimore, | permit. Page Department of Important: If any injury or once. | | 21. Signature of Funeral Service Licer | | | Name and Addre | collins | Funeral | Home In | ic. | |
| | | | 23a. Part1. Enter the disease, or com | plications that caused the dea | | | | | | ing, MD 20 | te |
| ų. | Physician /Medical | | shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | one cause on each line. a | SE quence of): | psis | | | | Interval Bet Onsel and | |
| | Examiner | | Sequentially list conditions | b | | | | | | | |
| 360 | Sit ad | iner | Sequentially list conditions, it are, leading to introduct cause. Enter Underlying Cause (Disease or injury | Diva to (or es a norsa | ошален (эт): | | | | | | |
| 8760, | cate be executed oblysicien and the burial-transit | dicai Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a conse | quence of): | | | | | | |
| 9 | ifficate g phys as the | edic | | | | | | | | | |
| O. Box | Attending Physician: The law requires that the death certificate be executed in death. setor: After this certificate has been signed by the attending physicien and better this certificate bas been signed by the attending physicien and by the tuneral director, page 2 should be detached for use as the burial-transit. | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown | al death 3 | □Ectopic pregnanc □ Other (specify) _ | ý | | 23d. Date Mor | e of delivery nth Day | Year |
| ٣. | that the by detail | | Part II. Other significant conditions of | ontributing to death but not re | sulting in the u | nderlying cause giv | ven in Part I. | 23e. Did to | obacco use contr | ibute to the cause of c | death? |
| ds | puires n sign | d b | MYOCARDIAL I | NEARCTION | ACUTO | RENAL | FAKUE | 36 10 | Yes 2□No | 3 Probably 4 P | Unknown |
| ecol | law rec as beel 2 shou | Completed by | | LOMA, HYDE | | | | 24a. Was | an 24b. V | Vere autopsy findings | available |
| <u>س</u> | The ate h | Con | | | | | | perfo | rmed? 📈 d | leath? □Yes 2□No | |
| /ita | cian: ertific ector. | Be | 25. Was case referred to medical examiner? | Honoitals. | | | | ath (Check only o | one) | | |
| 5 | Physi this al dir | 7 L | 1 ☐ Yes 2 ☐ No 27. Manner of Death | Hospital: 1 Impatient 2 [| ER/Outpatie | " 3LIDOA | | | dence 6 Othe | | |
| u C | ding I h. After funer | tion | 1 ☐Natural 5 ☐ Pending | (Month, Day Year) | 28b. Time of Injury | Wo | rk?]Yes 2 □No | 280. Describe | now injury occurre | 9 0 | |
| Division of Vital Records, P.O. | To the Hospitel or Attending Physician: The law within 24 hours effer death. To the Funerel Director: Affer this certificate has completely filled in by the funeral director, page 2 | Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined | e 200 Place of Injune. At h | nome, farm, st | | | 28f. Location (: City or Tox | | er or Rural Route Nurr | nber, |
| | To the Hospitel or within 24 hours efter To the Funerel Dir completely filled in it. | Medical C | | ysician: To the best of my kn niner: On the basis of examin and manner stated. | | | | | | | s) |
| | To the within 2 To the complet | Me | 29b. Signature and title of certifier | 0 1 | | 29c. Licens | | | | (Month, Day, Year) | |
| | r | | 1/Omul | reduct | Elin, M | DO DO | 05763 | 0 | 11-11- | - 2006 | |
| | φ | | 30. Name and address of person who Anuradha Arun, M | | m 23a) (Type, | | | | ing, MD | 20902 | |
| | Sta | ite | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | | W | | | J , | | |
| | Regist | | NOV 13 | 2006 | Dr. A | ARREL J | | | | | |

Mans

Please Type or Print in Black Indelible Ink

| Mansfield Albert F | 1 | ey State Of - For State Registrar | Maryland / Depa | rtment of I tificate of I | | | g. No. 200 | C 2760 |
|---|----------------|---|--|-----------------------------------|---|--|---|--|
| Physiciar Medical Examin | 1/ | 1. Decedent's Name (First, Middle,Last) Mansfield A. Hu | rlov Tr | | | 2. Date of Death Month November | Day Year | 2220 hrs |
| | | 4a. Facility Name (if not institution, give st | eet and number) | | City, Town, or Location of | | 4c. County of Death |) |
| Farmer | Ą | Anne Arundel Medical Cente 5. Social Security Number 6. Sex | 7. Age (In yrs. Ia | | Annapolis If Under 1 Year I If Under | er 24Hrs. 8. Date of Birt | Anne Arundel | tholace (State or |
| Funeral Director | | · I | 2 F | 25 _{Yrs.} | Months Days Hours | NA:- | Foreign | |
| d how any | | 10a. State 10b. County Iaryland Anne Art | 1 | Town or Location | 1 | | | 10d. Inside City Limits 1 Yes 2 No |
| the Marylan a or 28a-f s | Directo | 10e. Street and Number 5113 Sands Rd. | | | 10f. Zip Code 20711 | 10 | Og Citizen of What Cou | ntry? |
| Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Funeral | 1 X Never Married 2 Married | 2. Was Decedent Ever in U.s Armed Forces? Yes 2 X No | If Yes | Decedent of Hispanic Orig , specify Cuban, Mexican | , Puerto Rican, etc.) | White, etc. | ican Indian, Black, |
| urs after tural", | ᅙ. | 3 Widowed 4 Divorced If North 15. Decedent's Education (Specify only It | Dates: | 16a. Decedent's | es 2X No specify: Usual Occupation (Give | kind of work done | Specify: B1 | |
| 36 in 72 ho han "na lical Ex | Completed | Elementary/Secondary (0-12) | College (1-4 or 5+) | | t of working life. DO NOT Scaper | use retired) | Self Emp | loved |
| de with ygiene other the Mee | <u>ڇ</u> ا | 17. Father's Name (First, Middle, Last) | | Edita | | 's Name (First, Middle, M | | 10104 |
| 1215 1 be file ental H arked ovent, th | å | Mansfield A. Hur | | Tana and iii | | ricia L. | | |
| Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other transmatite event, the Media | 2 | 19a. Informant's Name/Relationship (Type Mansfield A. Hur | | | ddress (Street and Nun | | | |
| or Healt If item | | 20a Method of Disposition 1 X Burial 2 Cremation 3 | Removal from State | rematory or othe | | Date | 20c. Location - City or | |
| altimoni Pagariment portant: | - | 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee | | | oion Cem Tead Address of Facility Reese & | 11-10-06 | Clinton, | |
| | | Jarry J. Rose M. | 00483 | 82 | L West St. | Annapoli | s, Md. 21 | 401 |
| Physician /Medical xaminer | | | ^{line.} I <mark>ltiple Gunshot Woun</mark> | ds | mode of dying, such as c | cardiac or respiratory arre | est, shock, or heart | Approximate Interval Between Onset and Death |
| * | | Sequentially list conditions, b | e to (or as a consequence of | | <u> </u> | | | |
| - Jr. | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated | e to (or as a consequence of | | | | | |
| cuted nd transit | | events resulting in death) Last Due | to (or as a consequence of | f): | | | | |
| 60, ate be exe hysician a | Medical | | | | 2/2/07 TT | | · • · · · · · · · · · · · · · · · · · · | |
| | Physician/M | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregr 1 Live birth 4 Pregnant at time of de 9 Unknown | 2 Feta | death 3 Ectopion (Specify) | c pregnancy | 23d. Date of deliver Month | y Day Year |
| P.O. E es that the c | by Ph | Part II. Other significant conditions | ntributing to death but not re | esulting in the un | derlying cause given in Pa | | bacco use contribute to | |
| Records, P.C The law requires that icate has been signed I | | | | | | 24a Was a | an 24b. Were au | utopsy findings available |
| ecor he law 1 ate has b | Completed | | | | | autop: perfor 1 ✔ Yes 2 | med? death? | es 2 No |
| ian: T | ğ Be | 25. Was case referred to medical examiner? | | | 26.Place of Death | | | |
| f Vit | ္န | 1 ✓ Yes 2 No 27. Manner of Death | oital: 1 Inpatient 2 🗸 | ER/Outpatient 2Bb. Time of Inj | | | Residence 6 Othe | r. |
| Sion O | ation: | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) Nov. 2, 2006 | 2247 hrs | 1 Yes 2 ✓ | Subject shot | | |
| Division of Vital Records, ospital or Attending Physician: The law requir hours after death. meral Director: After this certificate has been sy filled in by the funeral director, page 2 should the funeral director, page 2 should the funeral director. | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At he (Specify) Single Fan | | factory, office building, e | tc. 28f. Location (S or Town, S 5113 Sands R | Street and Number or Rotate) Load, Lothian, MD | ural Route Number, City |
| | Medical C | one) 2 Medical Examiner: 0 | To the best of my knowled on the basis of examination and manner stated. | | | | | |
| E W E S | Me | 20b. Signature and title of certifier | 111 | | 29c. License number O.C.M.E. | | 29d. Date signed (Mc November 4, 20 | |
| | | 30. Name and address of person who con Laron Locke MD. Assistar | npleted cause of death (Item at Medical Examiner | | Street, Baltimore, M | MD 21201 | L | |
| Sta | | 31. Date filed (Month, Day, Year) | 32. Pagistrar's Signatu | | A B | | | |
| Registon DHMH 17 Rev 1/20 | | NOV 0 8 20 | 101 | OPICINAL | | | | |
| DI IIVII I I I I I I I I I I I I I I I I | 01 | | | ORIĞINAL | | | | |

State of Maryland / Department of Health and Mental Hygiene, 37687 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Nov. 6 2006 2:45a Ann H. Holland /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Severna Park Sunrise Assisted Living If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2X F 237-48-1898 24,1934 VA 72 Director Usual Residence of Deceden death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rat', or items 23a or 28e-f show Examinar west by notified at 1 ☐ Yes 2 ☑ No Severna Park Anne Arundel MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21146 43 W. McKinsey Road, Apt. 319 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: Specify. If Yes, Give Year or Dates þ 3 → Widowed 4 □ Divorced "natural", Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Howard County then College (1-4or 5+) 5+ Elementary/Secondary (0-12) Public Schools Registered Nurse 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be flik Department of Health and Mental Hy Important: if item 27 is marked oth any injury or othar traumatic event 17. Father's Name (First, Middle, Last) Be Corrie Lillian Wilkes Rupert Ray Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16 Vienna Court, Burnt Hills, NY 12027 Michael S. Holland/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 7, 2006 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD * 4 □ Donation 5 □ Other (Specify) 21 Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Ho 495 Gov. Ritchie Hwy, Severna Park, MD 21146 234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a d insequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or an a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical SE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.O. detached the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed has 2 🗆 No certificate 1□ Yes 2 No Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) A55151Cd examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification; To Living this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred completely filled in by the funeral 27. Manner of Death 28b. Time of After or Attending 1 Matural 5 Pending 1 TYes 2 🗆 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stafed. 29d. Date sigyled (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) Fo Ste 300 Annapoles MI 900 Cur Registrar's Signature 31. Date filed (Month State 0 Registrar

| 06-08451 | Please Type or Print in Black Indelible Ink |
|---------------------------|---|
| Stephon Joseph Hargrove | State of Maryland / Department of Health and Mental Hygiene |
| 1- For State Registrar | Certificate of Death |
| rtogist di | 2 Pete of |

| | | I-For State Registrar | | Ce | rtifica | te of | Death | | | | Re | eg. No. 2 (| 106 | 3760 |
|--|----------------|---|-------------------------------------|-----------------------------|------------|----------------|-------------------------------|---------|--------------|------------|---------------------------|-----------------------------|-------------------|--|
| Physicia | an/ | 1. Decedent's Name (First, Midd | dle,Last) | | | | | | | | Date of Deal | | 3 | Time of Death |
| Medical Exami | | STEPHON JOSEPH | | | | | | | | | Month November | | | 2350 hrs |
| | | 4a Facility Name (if not instituti Malcolm Grow Hospi | | umber) | | 4b | c. City, Town, Camp Sp | | | Death | | 4c. County o | | 3 |
| Funeral | 7 | 5. Social Security Number | 6. Sex | 7. Age (In yrs. | last birth | day) | If Under 1 Y | 'ear | If Under 2 | _ | 8. Date of Bir | th(MM/DD/YYYY) | | place (State or |
| Director | | 213 11 2518 | 1 X M 2 F | | 20 | Yrs. | Months D | ays | Hours | Min. | 12/08 | /1985 | Foreign Coun | try) MARYLAND |
| | ŀ | Usual Residence of Decedent | | | | | | | | | | | | |
| aus | | 10a. State 10b County | | 10c. City | , Town o | r Locatio | n | | | | | | - 1 | 0d Inside City Limits |
| nd show | ٦ | MD PRINC | E GEORGES | FOR | REST | VILL | E | | | | | | | Yes 2 No |
| Maryland 28a-f show any d at once, | Director | 10e. Street and Number | | | | | 10f. Zip Cod | е | | | 1 | 0g Citizen of Wh | at Countr | y? |
| ith the Maryland 23a or 28a-f she notified at once | ă | 8408 LENASKIN | LANE | | | | 20 | 747 | 7 | | | UNITED | STA | ΓES |
| with ns 23 | <u>a</u> | 11. Marital Status | | ecedent Ever in U | J.S. | | | | | | ofy Yes or No | | | n Indian, Black, |
| death or iter | Funeral | 1 X Never Married 2 | Married Armed I | 2 X No | | ir r e: | s, specify Cu | ban, r | viexicari, P | ueno Ri | can, etc.) | White | , etc. | |
| after al", c | Ď. | 3 Widowed 4 Di | vorced If Yes, Give Ye or Dates: | ear | | | Yes 2 X | | _ | | | Specify ⁻ | BLA | |
| 5-0036 lied within 72 hours after death with the Maryland Hygiene. I other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once | | 15. Decedent's Education (Sp | | | | | s Usual Occu st of working | | | | | 16b. Kind of Bus | siness/Inc | lustry |
| 16 n 72 nan " | Completed | Elementary/Secondary (0-12 |) College | (1-4 or 5+) | , | | | | | | | | | |
| 003 withi | E . | 12TH 17. Father's Name (First, Middle |) Last) | | | JNEM. | PLOYED | 18 | Mother's | Name /F | irst Middle I | NONE Maiden Surname) | | |
| filed I Hys | | | | | | | | | LINDA | | | vialuen ourname) | | |
| 21215-0036 Auld be filed within 7 Mental Hygiene marked other than | o Be | BENJAMIN HARGR 19a. Informant's Name/Relation | | | 19b. | Mailing | Address (S | _ | | | | nber, City or Town | n, State, Z | (ip Code) |
| imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic | H | LINDA GALLION | | | 119 | | LENASK | | | | | | | 111 |
| ore, MD es I and 2 sho of Health and If item 27 is | 1 | 20a. Method of Disposition | / MOTHER | 20b. | Place of | Disposit | on (Name of | | | | Date | VILLE, 1 20c. Location - | City or To | own, State |
| OFE ges 1 t of F : If i | | 1 X Burial 2 Crematic | on 3 Removal | from State | cremato | - | | 37 A T | CTD. | 1.1 | /1 / /0/ | OTT WIT | A 3.TT | MD |
| Baltimore, permit. Pages I an Department of He Important: If ite | 1 | 4 Donation 5 Other S | | [WA | SHING | TON 22 Na | NATIO | NAI | f Facility | . 11 | ./14/06 | SUITL | | |
| Baltimo permit. Page Department o Important: injury or oth | | 2 Tallaco de la constanción | Plant |) 2 2 | | M | ARSHAL 308 SU | LTT | FUN | ERAI | L HOME | OF MARY | LAND, | , INC. |
| Physician | | 23a. Part . Enter the disease, o | | caused the death | n. Do not | enter the | e mode of dyi | ng, su | uch as card | diac or re | espiratory arr | est, shock, or hea | art 20 | Approximate Interval |
| /Medical | 8 4 | fallyre. List only one caus | 0 | Nound of Ch | est | | | | | | | | . 8 | Between Onset and Death |
| Examiner | | Immediate Cause (Final diseas or condition resulting in death) | | a consequence | | | | | | | | | _ | |
| · · · · · · · · · · · · · · · · · · · | | Sequentially list conditions, | b | | | | | | | | | | _ | |
| | <u>i</u> | if any, leading to immediate cause. Enter Underlying Cause | | a consequence | of): | | | | | | | | | |
| _ | Examiner | events resulting in death) Last | | a consequence | of): | - | | | | | | | | |
| 50, te be executed ysician and burial - transit | 9 | | d | | | | | | | | | | | |
| 50, te be exe ysician a | n/Medical | UNPENDED | AMENDED | | | | | | | | | | | |
| 8760, rifficate by ng physic as the bur | ₩ W | IF FEMALE: 23b. Was decedent pregnant in | | , outcome of pre | | | | | 7 | | | 23d. Date of | | |
| 68 certifi nding se as t | ä | past 12 months? | Live | pinth gnant at time of d | _ | | al death er (Specify) | 3 | Ectopic p | regnand | у | Month | Da | y Year |
| Box 6 | Physicia | 1 Yes 2 No 9 U | nknown | nown | 5 | Oth | el (opecity) | | | | | | | |
| O. B at the da I by the tached | | Part II. Other significant cond | itions contributing | to death but not | resulting | in the ur | nderlying cau | se giv | en in Part | I. | 23e. Did to | bacco use contri | bute to th | e cause of death? |
| P.O. es that the iigned by be detacl | d b | | | | | | | | | | 1 Yes | 2 V No 3 | Probal | oly 4 Unknown |
| ords, P w requires to seen sign should be e | ete | | | | | | | | | | 24a Was | | | psy findings available impletion of cause of |
| COI e law e has e 2 st | Completed | | | | | | | | - | _ | perfo | rmed? d | eath? | |
| tal Recian: The certificate ector, page | | 25. Was case referred to medic | nal I | | | | 26 P | 2CB 0 | f Death (C | heck on | 1 Yes | 2 No 1 | ✓ Yes | 2 No |
| Division of Vital Records, tal or attending Physician: The law requirn rs after deart. The Invector: After this certificate has been sited in by the funeral director, page 2 should be | a | examiner? | Hospital: | Inpatient 2 | ER/Ou | tpatient | | | thor - | | | Residence 6 | Other: | |
| of V g Phy fter th | <u>ا</u> | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Dat | e of Injury | | ime of In | | Injury | at Work? | | | how injury occurre | ed | |
| ion of tending Pheath. | tion | | riding | th Day Year) 2006 | 2311 | hrs | 1[| Ye | s 2 🗸 N | lo S | ubject sho | t | | |
| /iSiO r Atten ter death irector: | fica | | estigation 28e. Pla | ace of Injury - At I | nome, far | m, street | t, factory, office | ce bui | ilding, etc. | 2 | | | er or Rura | Route Number, City |
| Div pital o ours af filled i | Certification: | 4 V Homicide det | |) Local Stre | eet | | | | | 24 | or Town, 8 110 Ritchie | Road, District H | leights, l | MD |
| Hosp 24 ho Fune stely f | al C | 20a Cortifier | Physician: To the b | est of my knowle | dge, deat | th occurr | ed at the time | e, date | e and place | e, and de | ue to the caus | se(s) and manner | as starte | d |
| Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. To the Funeral Directors: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | Medical | one) 2 Medical Ex | caminer: On the basi and manner | | and/or in | vestigation | on, in my opii | nion, d | death occu | irred at t | he time, date | and place, and d | ue to the | cause(s) |
| F % F 5 | ž | 29b Signature and title of certif | | \wedge | | | 29c. Lic | | | | | 29d. Date signe | ed (Monti | n, Day, Year) |
| | | 1 Olula | le oll | | | | 0. | C.M | I.E. | | | November | 7, 2006 | |
| | | 30. Name and address of Ferso | | | | | | | | | | | | |
| P (5) | U | | Assistant Medic | al Examiner | 111 | Penn | Street, Ba | altim | ore, MD | 2120 | 1 | | | |
| | tate | 31. Date filed (Month, Day Yea NOV 132 | 006 | Registrar's Signa | ture | use | , | | | | | | | |
| Regis | ueli | 1101 40 4 | VVV JURE | N. 10. | 17 | | | | | | | | | |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

| | | For State Registrar Ameno#5. PenFH RC 11-13-06 cr Cent | tificate of De | ath | Reg | . No. 200 | 5 3768 |
|--|----------------|--|-------------------------------------|--|--------------------------------------|---|--|
| Physicia Medical Examin | m | 1. Boodant o reamo (1 mot, madio, Ediot) | gins | | Date of Death Month November | Day Year 8, 2006 | 3 Time of Death O |
| | ı | 4a Facility Name (if not institution, give street and number) Prince George's Hospital | 4b. Cit | y, Town, or Location of De | | 4c. County of Deat | |
| Funeral Director | | 5. Social Security Number 5.79 – 92 – 8243 6. Sex 1x M 2 F | st birthday) If L | Inder 1 Year If Under 24 | Hrs. 8. Date of Birth Min. 1/9/1 | (MM/DD/YYYY) 9. Bit | rthplace (State or gn Washingt buntry) on DC |
| nd how any ce. | _ | Usual Residence of Decedent | Town or Location | | | | 10d. Inside City Limits 1 X Yes 2 No |
| r death with the Maryland or items 23a or 28a-f show any must be notified at once. | Director | 10e. Street and Number 2113 Virginia Ave | 10f. | Zip Code 20785 | 109 | g. Citizen of What Cou | intry? |
| , MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Menial Hygiene frem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once | by Funeral | 11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Dates. | If Yes, sp | edent of Hispanic Origin? ecify Cuban, Mexican, Pu 2 X No specify: | | 14. Race - Amer White, etc Specify. Bla | ican Indian, Black, |
| 36 in 72 hours han "natur lical Exami | ted | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 | during most of | ual Occupation (Give kind working life. DO NOT use ployed | | None | Industry |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner | Be Comple | 17. Father's Name (First, Middle, Last) Daniel L Huggins Sr | onemp | - | ame (First, Middle, Ma ie Ruff: | , | |
| MD 21 nd 2 should lath and Mer m 27 is mar | To | 19a. Informant's Name/Relationship (Type, Print) Eugene Huggins, Brother | | ess (Street and Number er Dr #30 | 1 Warren | ton Va 20 | 0816 |
| Baltimore, pernit Pages I an Department of Hei Important: If ite | | 1 X Burial 2 Cremation 3 Removal from State M. Comparison 5 Other Specify | olivet | Cemetery 1 | 1/14/06 | _ | on DC |
| Balt permit Depart Impor injury | | 21 Signature of Fig. at 1 Service Licensee | 172 | and Address of Facility T 2 North Ca | pitol St | NW Wash | |
| Physician /Medical \(\text{xaminer}\) | 100 | 23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of the condition resulting in death) | o chest and rig | | ac or respiratory arres | st, shock, or heart | Approximate Interval Between Onset and Death |
| | niner | Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated |): | | | | |
| | cal Examiner | events resulting in death) Last Due to (or as a consequence of d. UNPENDED AMENDED |): | | | | |
| Ox 68 ath certif | sician/Medical | IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown g Unknown | 2 Fetal de | | egnancy | 23d. Date of deliver Month | y Day Year |
| P.O. E es that the c grand by the c detached | by Phy | Part II. Other significant conditions contributing to death but not re | esulting in the underl | ying cause given in Part I. | 1 Yes | | the cause of death? bably 4 Unknown |
| E - 12 F | Completed | 25 Was association to marked. | | 26.Place of Death (Ch | 24a. Was an autops perform 1 Yes 2 | y prior to ned? death? | completion of cause of |
| n of Vital ling Physician After this cert funeral directo | To Be | 27. Manner of Death 28a Date of Injury | ER/Outpatient 3 28b. Time of Injury | Other | ursing Home 5 7 | desidence 6 Othe | r: Scene |
| _ = - ^ 2 | Certification: | 1 Natural 5 Pending Nov 7, 2006 Nov 7, 200 | 2324 hrs | 1 Yes 2 ✓ No tory, office building, etc. | 28f. Location (St | | ural Route Number, City |
| | dical Certi | 4 V Homicide determined (Specify) Sidewalk 29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination are | | | and due to the cause | venue, Landover, N (s) and manner as star | rted. |
| To the within To the comple | Medi | 29b Signature and title of certifier | and investigation, in | 29c. License number O.C.M.E. | ed at the time, date a | 29d. Date signed (Mo November 8, 20 | onth, Day, Year) |
| cp (5) | | 30. Name and address of person who completed cause of death (Item Ana Rubio MD. Assistant Medical Examiner | | t, Baltimore, MD 21 | l 201 | | |
| St. Regist | ate | 31 Date filed (Month, Day, Year) NOV 13 2006 | berti | | | | |
| Dhivin 17 Rev 1720 | | January St. A | ORIGINAL | | | | |

| | | r lease i | State of Maryla | | | | • | | gibic. | |
|--|---------------------|---|---|--------------------------------------|--|--|---|--------------------------|--|---|
| | | 1 State | State of Maryla | | tificate of | | | | 006 | 37690 |
| | | Registrar 1. Decedent's Name (First, Middle, Last) | .) | 0071 | modic or | Death | 2. Date of Deat | g. No." | | 3. Time of Death |
| Physi /Med | | Larry | tep | Jev | 45 Cit T | - 1 ti-d -t C ti | MOVO , | Day | 2000 | 0920 AM |
| Exam | niner | 4a Facility Name (If not institution, give s | ace at th | elake | Sal | r Location of Death | M | V | Unity of Death | mico |
| Funera Directo | | 5. Social Security Number 225-72-8033 6. Sex | 7. Age (In yrs | s. last birthday)_ Yrs. | Months Days | | 8, Date of Birth (Month, Day, July 22 | Year) 19 | 9. Birth Cou 50 Vir | place (State or Foreign ntry) Sinia |
| pug * | | Usual Residence of Decedent 10a. State 10b. County | 10c. (| City, Town or Loc | ation | | | | | IOd. Inside City Limits |
| a-f eho | ctor | | | | Cambric | lge | | | | 1 ☐ Yes 2 ☐ No |
| 3a or 28 | Dire | 10e. Street and Number 410 Oakley St. | | | 10f. Zip Code | 21613 | 10 | 0g. Citizer | n of What Cou | ntry? USA |
| death | nerg | 11. Marital Status | 12. Was Decedent Ever in Armed Forces? | U.S. 13. W | as Decedent of I | Hispanic Origin? (S van, Mexican, Puert | pecify Yes or No- | 14. | Race - Ameri Black, White, | |
| CLEINION MANAGEMENT OF THE MAN | by Funeral Director | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 Pres 2 No If Yes, Give Year or Dates: 1968 | | Yes 2 | | o moun, oto., | Sp | pecify: | nite |
| 72 hou | ted | 15. Decedent's Edu | cation | 16a. Decede | ent's Usual Occuping of work done | pation during most of wor | rkina | 16b. Kind | of Business/Ir | |
| within 900. | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | | o not use retire Presider | during most of wor ad) 1 | | Н | ealth (| Care |
| d ta b | To Be Co | Tod Hoppor | | | | 18. Mother's Nar | ne (First, Middle, M Lucy Rich | | mame) | |
| Maryla d 2 should th and Men t7 ie marke traumatic | | 19a. Informant's Name/Relationship (Ty.) Robert E. Young/P. | | | , | | alisbury | | | Code) |
| MOFE, Pages 1 an nent of Heal int: if item 2 | | 20a. Method of Disposition | 20b. | Place of Dispos cemetery, crem | ition (Name of atory or other pla | ice) | Date | 20c. Locat | tion - City or T | |
| 글 글 된 본 글 | ä | 1 Burial 2 Cremation 3 4 Donation 5 Dother (Specify) | | nenandoa | | | | | hester | , VA |
| n gges | Suc | 23a Part 1. Enter the disease, or compile | Cation that caused the de | ath Do not ente | 8 High | St., Camb | neral Hon ridge, M | 21 st | 613 | Approximate |
| Physicia | | Immediate Cause (Final disease or condition | ne cause on each line. ACOURRD | | | | | YND | ROMB | Interval Between Onset and Death |
| /Medica Examine | | resulting in death) | Due to (or as a conse | equence of): | | BACTBRI | . ' | VIU. | M | |
| bed isit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a conse | | | | | | | |
| if bU , te be executed ysicien and ne burial-transit | | resulting in death) cast | Due to (or as a conse | equence of): | | | | | | |
| 66/7 dificate by physic as the b | dicai | | 1 | | | | | | | |
| death cert death cert e ettendin ed for use | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown | ital death 3 🔲 | Ectopic pregnand Other (specify) _ | су | | 23d | I. Date of deliv Month | ery Day Year |
| that the detail | by Phy | Part II. Other significant conditions con | ntributing to death but not re | esulting in the un | derlying cause gi | ven in Part I. | 23e. Did tob | acco use | contribute to t | he cause of death? |
| ecords law requires as been sign | ted t | | | | | | 1 ☐ Ye | vi | No 3 ☐ Proi | bably 4 □Unknown |
| I KeC The law ate has b page 2 s | Completed | | | | | | 24a. Was an autops perform | y | 24b. Were auto prior to co death? 1 ☐ Yes | opsy findings available impletion of cause of |
| VITAL P sician: Th certificate irector, pag | 8 | 25. Was case referred to medical examiner? | Hospital: V | | | hac | ath (Check only on | | | |
| Of Physical directions of the Physical direction | | 1 Tes 2LINO | 28a. Date of Injury | ☐ ER/Outpatient 28b. Time of | 3 DOA 28c. Inju | 4 Nursing F | ome 5 ☐ Reside | | | (y) |
| ISION (titending I death. ctor: After y the funer | ation | 1 Natural 5 Pending 2 Accident investigation | (Month, Day Year) | Injury | | ork?]Yes 2 ☐No | | | | |
| > = = = = | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At building, etc. (Spec | home, farm, stre cify) | et, factory, office | | 28f. Location (St. City or Town | | lumber or Rur | al Route Number, |
| To the Hospital of within 24 hours af To the Funeral D completely filled in | Medical | | sician: To the best of my k iner: On the basis of exami and manner stated. | nowledge, death nation and/or inv | occurred at the t estigation, in my | ime, date and place opinion, death occu | e, and due to the caurred at the time, da | use(s) an ate and pla | nd manner as s ace, and due t | stated. o the cause(s) |
| To the within 2 To the comple | M | 29b. Signature and tittle of certifier | • | | 29c. Licen | se number | | | signed (Month, | |
| | | 186 | 7 m | <u> </u> | | 058410 | | 11 | 14/06 | 5 |
| | | 30. Name and address of person who co | 5 26266 | ARRO | | OCT. | SAUSI | RUR | y u | W.21801 |
| | State istrar | | 32. Registrar's Sig | nature | boarde | | | | | , |

| | | | St L_ State | ate of Maryland | , | rtment of H | | | 211116 | 37691 |
|----------------------------|---|---------------------------|--|--|------------------------|--|----------------------------------|---------------------------|---------------------------------------|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | | Cert | ilicate of L | | P. Date of Dea | leg. No: | 3. Time of Death |
| | Physici | an | | T | | | | Month | Day_ Year | 1. US PM |
| | /Medic | | Leo Breslin 4a. Facility Name (If not institution, give street | Iserman | Т | 4b. City, Town, or | Location of Death | Everio | 4c. County of Death | 7 1.10. |
| | Examin | eı | Civista Med | incal (e | nten | If Under 1 Year | Plata | I. Date of Birtl | Char | place (State or Foreign |
| | Funeral Director | | 5. Social Security Number 6. Sex. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | ^{2□} F 67 | Yrs. | Months Days | Hours Min. | (Month, Day | v, Year) Cou | rginia |
| | | ⊦ | Usual Residence of Decedent | | | | - Aug | Sust_1 | T CCT + | |
| | ehow | | 10a. State 10b. County | 10c. City, | Town or Loc | ation | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| | Ba-f e | 5 | MD Charles | P | omfre | | | | | |
| | vith th | E E | 10e. Street and Number | 1 | | 10f. Zip Code | 7.5 | | 10g. Citizen of What Cou | intry? |
| | e 23e | era | 4537 Stratford R | Oad Vas Decedent Ever in U.S. | 13 W | 2067 | /) ispanic Origin? (Spec | ify Yes or No- | USA 14. Race - Amer | ican Indian, |
| 36 | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23a or 28a-f ehow other traumatic evant, the Madical Example, must be multilisd at | by Funeral Director | 1 ☐ Never Married 2 Married 1 | med Forces? X Yes 2 □ No Yes, Give /ear or Dates: | If | Yes, specify Cuba ☐ Yes 2 XNo | n, Mexican, Puerto R Specify: | ican, etc.) | Black, White Specify: Wh | , etc. |
| 21215-0036 | 2 hou | Completed | 15. Decedent's Educatio (Specify only highest grade cor | | | ent's Usual Occupa | ation during most of working | 7 | 16b. Kind of Business/l | ndustry |
| 218 | en "n | npie | | College (1-4or 5+) | life. D | O NOT use retired | i) | ' | _ | |
| 21 | ed wi | S | 12 | | Bro | ker | 18. Mother's Name | Tinnt Adidate | Real Est | ate |
| Maryland | d 2 should be filed within 7 h and Mental Hygiene. 7 is marked other then "r traumatic evant, the Mad | Be | 17. Father's Name (First, Middle, Last) Joseph J. Iserma: | n | | | Rose Mai | | | |
| 3 | d Mer d Mer nark | P | 19a. Informant's Name/Relationship (Type, F | | 19h Mailine | Address (Street | | | or, City or Town, State, Z | ip Code) |
| <u>≅</u> | d 2 si th an th an trau | | Shirley Iserman/ | | 4537 | A STATE OF THE STA | | | et.MD 206 | |
| | of Health of Health ltem 27 i | | 20a. Method of Disposition | 20b. Plac | ce of Dispos | ition (Name of atory or other place | Da | | 20c. Location - City or 1 | |
| OL | Pages nent of I int: If Its iry or o | | 1 ☐ Burial 2X☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify) | | | | | /06 | harlotte | Hall,MD |
| Baltimore, | 프론원들 . | | 21. Signature of Funeral Service Licensee | M0094 | E . | | | | L HOME,P. | • |
| ä | Depa Impo any I | |) Havil C. Ec | hul) | 2 | 11 St. | Mary's A | ve. I | a Plata M | D 20646 |
| | | | 23a. Part T. Enter the disease, or complication shock, or heart failure. List only one can | ons that caused the death. | | | g, such as cardiac or | respiratory ar | rest, | |
| | Physician | | tmmediate Cause (Final disease or condition | ALZHE | IME | ER'S | DEME | NT | EA | Onset and Death |
| 7 | /Medical | | resulting in death) | Due to (or as a conseque | ence of): | | | | | |
| В | Examiner | | Sequentially list conditions, b. | D - 1 - (| | | | | | |
| | 9d sit | ine | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conseque | ince ot): | | | | | |
| | xecut and II-tran | Examiner | that initiated events c resulting in death) Last | Due to (or as a conseque | nce of): | | | | | |
| 8760, | certificate be executed ding physicien and use as the burial-transit | dical E | | | | | | | 2/3 | |
| 687 | ficate g phys | edic | 0 | | | | | | | |
| Box | death e atter | Completed by Physician/Me | in the past 12 months? | f yes, outcome of pregnand 1□Live birth 2□Fetal d 4□Pregnant at time of dea 9□Unknown | leath 3 🗌 | Ectopic pregnancy Other (specify) | , | | 23d. Date of deli Month | very Day Year |
| P.0 | requires that the een signed by th nould be detache | F. | Part II. Dther significant conditions contribu | uting to death but not result | ting in the ur | derlying cause giv | en in Part I. | 23e. Did to | obacco use contribute to | the cause of death? |
| ds | w requires that been signed to should be deta | D D | HYPERT | ENSTO | N | | | 101 | res 2 No 3 Pro | obably 4 Unknown |
| Division of Vital Records, | > 0 2 | oiete | | | | | | 24a. Was | | topsy findings available |
| Re | o = = | mo | | | | | | autop perfo 1 ☐ Yes | rmed? death? | completion of cause of |
| ta | ilcian: Th certificate rector, pag | a | 25. Was case referred to medical | | | | 26. Place of Death | | | |
| Ž | \$.∞ 5 | To B | examiner? 1 Yes 2 No | itat: 1 XInpatient 2 ☐ El | P/Outpatien | | 4 Nursing Hon | e 5 ☐ Resid | dence 6 Other (Spec | ify) |
| 0 [| nding Ph ith. : After th e funeral | | 27. Manner of Death 2 1 Naturat 5 Pending 2 | 8a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injur Wor | | 3d. Describe I | now injury occurred | |
| Sio | tendileath. | cati | 2 Accident investigation | | | | Yes 2 □No | Of Landing (| Street and Mumber of B | and Courte Alicenter |
| Ξ | or At | Certification; | 4 Homicide determined 2 | Ptace of Injury - At hom building, etc. (Specify) | ne, tarm, stre | et, factory, office | 2 | City or Tox | Street and Number or Ru vn, State) | rai Houte Number, |
| _ | To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the | Medical Ce | | nn: To the best of my know On the basis of examination | | | | | | |
| | To the Hos within 24 h To the Fur completely | Mec | 29b. Signature and title of certifier | and manner stated. | * | 29c. Licens | e number | | 29d. Date signed (Month | ı, Day, Year) |
| | ⊬≱≓ö | | V, Anu | and - | | DL | 0064 | _ | 11-9 | -2006 |
| | | | 30. Name and address of person who compl | eted cause of death (Item 2 | 23a) (Type, | Print) | 1 | | | |
| 3 | B761 | | Anmangandla, V | | r, mo | 10583 | 3 Theadon | 2Gree | in Blvd. Wr | ITE POINS, M |
| | | ate | 31. Date filed (Month, Day, Year) | 32. Registar's Signatu | ILE M | hand . | | | | 0000 |
| | Regist | rar | IAOA T 2 (| 006 Steren | 10 | ypour | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes of A

| | | | for State Registrar | State of Mary | | artment of <i>rtificate of</i> | | | lene 006 | 37692 |
|---------------------|---|---------------------|---|--|--------------------------------------|--|---|---|--|---|
| | Dhusisi | | 1. Decedent's Name (First, Middle, Last) | , | | | | 2. Date of Deat Month | | 3. Time of Death |
| | Physici /Medio | | Nahideh. | Jenabz | adeh | | | NOV | 8 2006 | , 1437 M |
|) | Examir | er | 4a. Facility Name (If not institution, give s | | | | or Location of Death | | 4c. County of Dea | |
| _ | | | Shady Grove 5. Social Security Number 6. Sex | Hospital 7 Age (Ir | yrs. last birthday) | Rockv | | 8. Date of Birth | Montgo | |
| | Funeral Director | | | M 25xF 7 | | Months Days | | 8. Date of Birth (Month, Day, 7 / 1 9 / 1 | 726 - | thplace (State or Foreign ountry) ran |
| | yland Now | | 10a. State 10b. County | 10 | c. City, Town or Lo | ecation | | | | 10d. Inside City Limits |
| | Mar. | ctor | MD Montgome | ery | North Po | otomac | | | | 1 ☐ Yes 2 🔀 No |
| | or 28 | Jr.e. | 10e. Street and Number | | | 10f. Zip Code | | 11 | g. Citizen of What C | ountry? |
| | ath w | ral | 11504 Brandy Ha | | | 20878 | | | Iran | |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examination must be profiled an once. | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | | Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☑ No | Hispanic Origin? (Spoan, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Am Black, Whi | te, etc. |
| у О | 72 hc | Completed | 15. Decedent's Educ (Specify only highest grade | cation completed) | 16a. Dece | dent's Usual Occu | pation during most of work ed) | ting | 6b. Kind of Business | Andustry |
| 12 | vithin ne. hen | ldm | Elementary/Secondary (0-12) | College (1-4or 5+) | | | ed) | | 1 | |
| , D | filed v Hygie ther t | ပိ | 17. Father's Name (First, Middle, Last) | - | nous | sewife | 18 Mother's Nam | e (First, Middle, N | home | |
| an | d be ental ked o | To Be | Mirza Jenabzad | leh | | | Hamid | | shar | |
| 37 | should nd Men marke umatic | - | 19a. Informant's Name/Relationship (Type | oe, Print) | 19b. Mailir | ng Address (Stree | t and Number or Rur | al Route Number, | City or Town, State, | Zip Code) |
| | and 2 ealth a n 27 is | | Hooman Beygi / | son | 1150 | 4 Brand | y Hall L | n.Potor | nac, Md. | 20878 |
| nore | Pages 1 and of He int: if item | | 20a. Method of Disposition 1 By Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) | emoval from State | Ob. Place of Dispo cemetery, crer | | | | Oc. Location - City or Suitla | |
| Baltimore, | permit. P Depertme Importan any injur | | 21. Signature of Funeral Service Utense | A. A. | 22 | . Name and Addr | ess of Facility Un | iversal | Mortuar | У |
| | 20 = 4 O | | 23a. Part1. Enter the disease, or complic | are | 4 | 11 Keni | nedy St. | N.W. W | ashingto | n,DC20011 |
| | | | snock, or near failure. List only on | e cause on each line. | 1 . | | | | st, | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | aspira | ution | men | monia | | | 36 hours |
| | Examiner | | | | | | | | | |
| | | er | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a co | nsequence of): | | | | | |
| | outed od ransit | Examiner | Cause (Disease or injury that initiated events | | | | | | | |
| Ö, | e exer ien ar urial-t | Ex | resulting in death) Last | Due to (or as a co | nsequence of): | - | | | | |
| 68760, | ificate be executed g physicien and as the burial-transit | edical | d | | | | | | | |
| _ | | /Me | IF FEMALE: | 3c. If yes, outcome of p | recoancy | | | | | |
| . Box | res that the death certificate be executed igned by the attending physicien and be detached for use as the buriat-transit | Iclan/M | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No | 1 Live birth 2 ☐ 4 Pregnant at time | Fetal death 3 | Ectopic pregnand Other (specify) _ | ey | | 23d. Date of de Month | livery Day Year |
| 0. | by the | Physi | 9 ☐ Unknowh | 9□ Unknown | | | | | | |
| | es thi | þ | Part II. Other significant conditions con | tributing to death but no | ot resulting in the ur | nderlying cause gi | ven in Part I. | 23e. Did tob | acco use contribute to | the cause of death? |
| ord | w require been sign should b | ted | | | | | | 1 🗆 Ye | s 2 No 3 P | obably 4 Unknown |
| Vital Records, | The la ete has page 2 | Completed | | | | | | 24a. Was an autopsy perform | ed? prior to death? | utopsy findings available completion of cause of 2 No |
| Ĭ | iclan: Th certificete rector, pag | Be | 25. Was case referred to medical examiner? | ospital: N | | 100 | | h Check only one | | |
| | 른 등 = | 5 | 1 ☐ Yes 2 X No | atient | 2 ER/Outpatien 28b. Time of | 1 3 DON | | me 5 Resider | nce 6 Other (Spe | city) |
| 0 | th. : Afte | tlon | 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Ye | ar) Injury | Wo | rk? Yes 2 \ No | 2.00. Describe no | w injury occurred | |
| Division of | or Attending Patter death. Director: After to by the funera | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - building, etc. (S | At home, farm, stre | | | 28f. Location (Str. City or Town, | eet and Number or Ri State) | ural Route Number, |
| | To the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by | | 29a. Certifier Certifying Phys | ician: To the best of m | y knowledge, death | occurred at the t | me, date and place, | and due to the ca | use(s) and manner as | stated. |
| | thin 24 thin 24 the F | Medical | 29b. Signature and title of certifier | er: On the basis of exa and manner stated. | mination and/or inv | /estigation, in my | | | te and place, and due d. Date signed (Mont | |
| | 7 | | > Polosos | 0- | | | | 1 | _ | - |
| | | | 30. Name and address of person who cor | npleted cause of death | (Item 23a) (Type | Print) | 064302 | - | 10V 9, | 2006 |
| _ | | | Brian CARPENTER | C. A. | dical (| Center | 2 Drive | Rockvil | Jov 9, le,MD; | 20850 |
| 177 | Sta | | 31. Date filed (Month, Day, Year) NOV 1 3 200 | 32 Registrar's | Signature | ule | 1 | | | |
| | Registr | ar | MON TO SOU | ETE WELLS | No. Valori | - 0 | | | | |

| | | | 1- For Amend #8 Per Registrar | FH ^{State} of 1 | 12996 |) 9 / Step Ce | artmer <i>rtificat</i> | it of H | ealth a Death | and M | ental Hyg | jien o | 200 | 6 | 3769 | 3 |
|---------------------|---|-----------------|---|--|---------------------------|----------------------------------|--|--------------------------|----------------------------|-------------------------|---------------------------------------|----------------------|-------------------------|-------------------------|---|-----|
| s: | 1 Sept. | | 1. Decedent's Name (First, Middle, L | ast) | | | | | | | 2. Date of Dea | th | | | 3. Time of Death | 1 |
| 15 | Physic /Medi | | Maurice A | Jackso | n | | | | | - | Novembe: | Day | 200 | ear 6 | 6:45 P | М |
| | Exami | | 4a. Facility Name (If not institution, gi | ve street and numbe | or) | | 4b. City, | Town, or | Location o | | | | County of | | | |
| jadi . | | | Bethesda Rehab. | Center | | | Be | thes | :da | | | | Monte | Omer | •v | |
| | Funeral | | | Sex 7.7 | | last birthday) | If Under | 1 Year | If Under 2 | | 8. Date of Birth | | | Birthpla | ice (State or Fore | ign |
| 36 | Director | | 578-22-0167 | 1 X M 2□F | 79 | Yrs. | Months | Days | Hours | Min. | June Za | , 1 | 927 | Count Wash | D.C. | |
| | p . | | Usual Residence of Decedent | | 1 | | | | | | 21 | | | | | |
| | anyla ehov | _ | 10a. State 10b. County | | | ty, Town or Lo | | | | | | | | 10 | d. Inside City Limi | |
| | 8a-f | cto | Maryland Montgo | omery | Sil | ver Sp | ring | | | | | | | | 1X∏Yes 2 ☐ N | 10 |
| | or 2 | Director | 10e. Street and Number | - | | | 10f. Zip | | | | 1 | 0g. Citiz | zen of Wh | at Count | ry? | |
| | 72 hours after death with the Maryland "naturet", or itame 23a or 28a-f show calcal Examinat the notified at | | 2133 Hidden Valle | y Lane | | | 20 | 904 | | | | Un: | ited | Stat | es | |
| | tamet | Funeral | 11. Marital Status | 12. Was Deceder Armed Force | nt Ever in U s?un kny | I.S. 13. | Was Deced | dent of Hi | spanic Orig | gin? (Spe , Puerto F | city Yes or No- Rican, etc.) | 1 | 14. Race - Black. | America White, e | | |
| 36 | or i | by F | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ② Divorced | Armed Force: 1 Yes 2 If Yes, Give | 3 // 11 11 1 1 | OWII | 1 ☐ Yes | | Specify: | | , | | Specify: | | | |
| 8 | hour turet | Q D | | Year or Dates |): | | | | | | | | | | | |
| 5 | | Completed | 15. Decedent's E (Specify only highest gi | ade completed) | | 16a. Dece | dent's Usua kind of wo DO NOT us | rk done a | lurina most | of working | ng | 16b. Kir | nd of Busir | ness/Indu | istry | |
| 12 | d within giene. r than | Ę | Elementary/Secondary (0-12) | College (1-4o | r 5+) | | n ci pa | , | , | | | т. | CDC | | | |
| 9 | be filed ntal Hygi od other event, li | e C | 17. Father's Name (First, Middle, Las | | | | пстра | 1 | 18 Mother | r's Namo | (First, Middle, M | | OCPS | | | |
| an | | 0 | Arthur Jackson | , | | | | | | | | naiueii . | <i>Sumame</i> | | | |
| 2 | should but Ment | 은 | 19a. Informant's Name/Relationship | (Type Print) | | 19b Mailie | Addeson | (Ctroot a | | | Allen | 0.4 | T 0: | | | |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked eny injury or other traumatic engos. | | Alfredda Payne | (siste | m) | | | | | | Route Number | | | | | |
| 0 | 1 an Heal em 2 | | 20a. Method of Disposition | (SISCE | - | Place of Dispo | DI CO | en v | аттеу | | e, Silv | | oprin cation - Cit | _ | | |
| ٥ | ages nt of : If it | | 1 ☐ Burial 2 ☐ Cremation 3 [| | _ 0 | cemetery, crer | natory or o | ther place | | | | | | | | |
| Baltimore, | rtme rtant njury | | 4 Donation 5 Other (Special | | CII | esapea | | | | 11/7 | | | svil | | | |
| Ba | Depa Impo eny i | | 21. Signature of Funeral Service Lice | nsee | | | | | | | ire Fun | | | | | |
| 200 | | | 23a. Part1. Enter the disease, or con | nongs | gu / | | | | | | N.W., W. | | D.C | | 0012 | |
| 192 | Pnysician /Medical | | shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | one cause on each | estiv | e Card | | | | cardiac or | respiratory arre | est, | | 1 | Approximate nterval Between Onset and Death | |
| 40 | Examiner | | | | | Mellit | 110 | | | | | | | | | |
| | 102 | er | Sequentially list conditions, if any, leading to immediate | b. Due to (or a | | | us | | | | | | | _ | | _ |
| | uted d ansit | Examin | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | | | | | |
| oʻ | ficate be executed physicien and s the burial-transit | Exa | resulting in death) Last | Due to (or a | s a conseq | uence of): | | | | | | | | | | - |
| 8760, | ysicie | dical | | d | | | | | | | | | | | | |
| 9 | tifica ng ph as th | ledi | | | | | | | | | | | | | | _ |
| Вох | death certifi e attending p id for use as | by Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcom | | | lm: | | | | | 2: | 3d. Date o | f delivery | | |
| <u>.</u> | 0 0 0 | icia | in the past 12 months? 1 ☐ Yes 2 ☐ No | 4☐Pregnant | | |]Ectopic pro] Other (sp | | | | | | Month | D | ay Year | |
| P.O. | t the by th tache | hys | 9 Unknown | 9□ Unknown | | | | | | | | | | | | |
| | The faw requires that the de ste has been signed by the a page 2 should be detached f | y P | Part II. Other significant conditions | contributing to death | but not resi | ulting in the ur | derlying ca | ause give | n in Part I. | | 23e. Did tob | acco us | e contribu | te to the | cause of death? | |
| Vital Records, | w require been si should b | ed | | | | | | | | | 1 ☐ Ye | s 2 K |]No 3[| Probab | oly 4 □Unknow | 'n |
| ပ္က | as be | Completed | | | | | | | | | 24a. Was ar | | 24b. Wer | e aulops | y findings availab | le |
| æ | The fav | E | | | | | | | | | autopsy | ed? | prior | to comp | pletion of cause of | |
| Ital | | BeC | 25. Was case referred to medical | | | | | | 26 Place 6 | of Doath | 1 ☐ Yes 2 (Check only one | □ No | 1 🗆 | Yes 2 | ∐ No | |
| > | % .s = 5 | ToE | examiner? 1 ☐ Yes 2 【XNo | Hospital: 1 ☐ Inpat | ient 2 🗆 | ER/Outpatien | 3 □ DO | Othou | - | | e 5 ☐ Reside | | Other (| Canada) | | |
| 0 | ding Ph h. After th funeral | | 27. Manner of Death | 28a. Date of In (Month, D | jury | 28b. Time of | | Bc. Injury Work | | | 3d. Describe ho | | | Specify) | | |
| <u>ō</u> | ath. r: Aff | atio | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio | | ay rear) | Injury | м | | / es 2 □ N | lo | | | | | | |
| Division of | or Attending ifter death. Director: After in by the funer | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Ir | njury - At ho | ome, farm, stre | et, factory | office | | 28 | Bf. Location (Str | | Number o | r Rural F | Route Number, | |
| $\overline{\Box}$ | s afte | Ser | | building, e | etc. (Specify | */ | | | | | City or Town, | State) | | | | |
| | To the Hoepital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the | edical | 29a. Certifier 1 ☑ Certifying Pt (Check only one) 2 ☐ Medical Exam | nysician: To the bes niner: On the basis and manners | or examınaı | wledge, death tion and/or inv | occurred a restigation, | at the time in my opi | e, date and nion, death | place, ar occurred | nd due to the ca d at the time, da | use(s) a te and p | ind manne place, and | r as state due to th | ed. ne cause(s) | |
| | To t | Σ | 29b. Signature and title of certifier | | | | | License | | | 29 | d. Date | signed (M | lonth, Da | y, Year) | _ |
| , | (| | Mexical | man | | NS | D | 2766 | 0 | | | 11/- | 6/0. | 6 | | |
| • | | | 30. Name and addless of person v | completed cause of | death (Item | 23a) (Type, I | Print) | | | | | / | | | | |
| | | | | M.D. 111 | 119 Rc | ckvill | e Pil | ke Su | ite 0 | G-100 | , Rockv | i 111 | e, MD | 20 | 852 | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 1 3 2 | | trar's Signa | | uli | | | | | | Me da es | | | 7 |

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

3 or be r ns 23a must b

"natural", or items

Medical

the

Pages 1 and 2 should be filed wi fment of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, the

Department of Important: If it any injury or c

Director

Funeral

Completed by

Be

filed within 72 hours after death with the Maryland

Maryland 21215-0036

3altimore,

o

٦

Division or Vital Records,

Hospital or Attending

physician ase for signed t page 2 certificate director, this After t

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION Completed by 25. Was case referred to medical examiner? Be Yes 2□ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier

uthin 24 hours after death.

the Funeral Director: A pmpletely filled in by the fu Medical within 2

torondsh

141417

29d. Date signed (Month, Day, Year) NOV.

21401

30. Name and address of person who completed cause of death (item 23a) (Type, Print) MEDICAL PARKWAY, SUITE

Louis ESSANDOH, MO K ANNAPOLIS

31. Date filed (Month, Day, Year)

2006 8 NOV 0



State

Registrar

06-08467 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Michael James Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 7, 2006 0140 hrs Medical Examiner Michael James 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Forestville 2728 Lorring Drive #303 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Davs Hours Min Director 30 04/19/1976 CWash., DC 577-98-8241 1X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 1 Yes 2 No 28a-f show District Heights Maryland | Prince George's or items 23a or 28a-f sho must be notified at once. hours after death with the Maryland Director 10g Citizen of What Country? 10e. Street and Number 20747 United States 2728 Lorring Dr., #303 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2 X No If Yes, Give Year 1 Yes 2 No specify: 4 Divorced Widowed tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner R1ack þ or Dates 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene ant: If item 27 is marked other than " 21215-0036 Unemployed None 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene James Shirley Armstrong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 07.47 19a Informant's Name/Relationship (Type, Print) #303. District Heights.

20c. Location - City or Town, State Shirley Armstrong/Mother <u> 2728</u> Lorring Dr 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State permit Page Department Harmony Memorial Park 11/11/2006

22 Name and Address of Facility Stayyart Po Donation 5 Other Specify Landover, MD 21. Signature of Funeral Service Licentee Stewart Funeral Home 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and fail re. List only one cause on each line /Medical Death a. Hypertensive Cardiovascular Disease Immediate Cause (Final disease or condition resulting in death) xaminer Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last that the death certificate be executed physician and the burial - trans Physician/Medical **AMENDED** UNPENDED Box 68760 23d. Date of delivery 23c. If ves. outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a I be detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I o þ 1 Yes 2 No 3 Probably 4 V Unknown ۵ the Hospital or Attending Physician: The law requires Completed Records, 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? ✓ Yes 2 1 🗸 Yes this certificate 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Hospital: 1 examiner? Other Nursing Home 5 DOA Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 1 🗸 Yes No 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: 1 V Natural Division 1 Yes 2 No Pending Director: death Accident Investigation 28f Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be or Town, State) Suicide determined Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated 9 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie November 8, 2006 O.C.M.E ess of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year) State Registrar

Pamela E. Southall, MD

Registrar's Signature

Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrat 37696 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Month FRED ROOSEVELT JACKSON November 04, 2006 1:35_A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 73 Yrs Director 220-40-5685 November 10, 1932 Danville, VA Usual Residence of Decedent the Maryland 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Mudical Examiner name be notified at 1 ves 2 □ No Maryland Prince Georges Director Springdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3812 Asquith Court 20774 iteme 23a USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Item 1 ⊠Yes 2 □ No 1952 If Yes, Give Year or Dates: 1955 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Federal Police Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Jackson Mabel Curbie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Della M. Jackson/Wife 3812 Asquith Ct., Springdale, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of Hi
Important: If ites
ony injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. Nov. 13, 2006 Cheltenham, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes; 5538 Marlboro Pike Forestville, Md. 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Atherosclerotic Cardiovascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by t d be detach Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Completed been Hypertnesion 24b. Were autopsy findings available prior to completion of cause of death? The law 24a. Was an certificate has autopsy performed? End Stafe Parkinson's Disease 1 ☐ Yes 2⊠ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death | Check only one Hospital: 1 🖾 Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending hours after death. investigation M 1 Yes 2 No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital or within 24 hours af To the Funeral D to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medica (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0037066 November 04, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uchechi Odaigbeogu, M.D. 6188 Oxon Hill Rd. #701; Oxon Hill, Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 13 2006 Registrar

| | | Please | • • | k indelible ink. Ensure Al | • | |
|---|---------------------|---|--|---|---|--|
| | | For | State of Maryland / I | Department of Health and M | lental Hygien | 2006 37697 |
| | | 1 - State Registrar | | Certificate of Death | Reg. N | Ö. |
| Physi | cian | Decedent's Name (First, Middle, L. | , | | Date of Death Month Date | |
| /Med | | William | Lorenzo | Johnson | November | 2,2006 2:45 PM |
| Exam | | 4a. Facility Name (If not institution, ga | | 4b. City, Town, or Location of Death | 40 | c. County of Death |
| | | House in | the Pines | tribday) If Under 1 Year If Under 24 Hrs. | | Talbot |
| Funera | _ | | Sex 7. Age (In yrs. last bit | rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | (Month, Day, Year | 9. Birthplace (State or Foreign Country) Mary/and |
| Directo | or | 157-05-1619 Usual Residence of Decedent | 76 | | Oct. 18,1 | 410 Marylana |
| land ow | | 10a. State 10b. County | 10c. City, Tow | vn or Location | | 10d. Inside City Limits |
| Mary (| ŏ | MD. Talk | not to | CANDO | | 1 ☐ Yes 2 ☑ No |
| the 28a | rec | 10e. Street and Number | 701 | rappe 10f. Zip Code | 10g. C | itizen of What Country? |
| 3e or | by Funeral Director | 29379-Ba | | 1 0 1 | | USA |
| death ms 2 | Jere | 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto | ecify Yes or No- | 14. Race - American Indian, |
| after or its | Ē | 1 Never Married 2 ☐ Married | 1 Pres 2 No 1942 | 1 Yes 2 No Specify: | nicari, etc.) | Black, White, etc. |
| ours ours | l by | 3 Widowed 4 Divorced | Year or Dates: 1946 | TEL 103 ZEE NO Spoony. | | Specify: Black |
| 72 h | Completed | 15. Decedent's (Specify only highest g | | Decedent's Usual Occupation (Give kind of work done during most of work | ing 16b. i | Kind of Business/Industry |
| ithin | id. | Elementary/Secondary (0-12) | College (1-4or 5+) | life. DO NOT use retired) | 4 | 111/2011 |
| Idality Z. I.Z. 12-10000 view little death with the Maryland lented Hygiene. Hygiene Hygiene Hygiene 1-1000 view lenter than "naturet", or items 23e or 28e-f ehow icevent, the Medical Examinat must be notified at | | 47 Februar Norma (Circh Middle Los | 1 | Clerk | e (First, Middle, Maide | of Sumama) |
| be fi | Be | 17. Father's Name (First, Middle, Las | . 124 1 | 1 | | |
| should be nd Mental marked c | 10 | James V | J. K. V.b.y | b. Mailing Address (Street and Number or Run | Johns | OV) |
| is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. The filed Franke of the marked other than "naturel", or items 23e or 28a-f show other traumatic event, the Medical Examinar must be notified at | 100 | Tod. Informant 5 Hamor tolations. | (.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | - | |
| T and lealthealthealthealthealthealthealthealt | 1 8 | HENRY GAY 20a. Method of Disposition | oner 7 | 423 - Koyal Ave. Pe | Date 20c. L | ocation - City or Town. State |
| Pages nent of the | | 1 1 Burial 2 □ Cremation 3 | cemete | erv. crematory or other blace! | | 111 |
| mit. Pages partment of portent: If i | | * 4 □ Donation 5 □ Other (Spec | ity) Vete | vans Cemetery // | 7/00 Hu | VIOCK, NID. |
| permit. Pages 1 a Department of He Importent: If iten | once. | 21. Signature of Funeral Service Lic | C. Deware | vans Cometery /// 22. Name and Address J Facility Henry Funeral Hom 510 Washington | e, P.A. | 11 110 21/13 |
| 4020 | <u> </u> | 230 Bart V Enter the disease or co | mulications that caused the death. Do | 510 Washing ten not enter the mode of dying, such as cardiac | ST. Cambr | Approximate |
| | | shock, or heart failure. List on | y one cause on each line. | not site the mode of dying, such as cardiac | or respiratory arrest, | Interval Between Onset and Death |
| Physicial | _ | Immediate Cause (Final disease or condition resulting in death) | a Cararon | yopetky | | years |
| /Medica Examine | _ | 1 | Due to (or as a consequence | 00 | | Man |
| | - I | Sequentially list conditions, | b. Due to (or as a consumence | msufficiency | | geans |
| ted nsit | 벁 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Manuel | uni(| | Hears |
| y execu n and al-tra | Examiner | resulting in death) Last | c. ue o (or as a consequence | o of): | | |
| death certificate be executed eattending physician and of or use as the burial-transit | cai | | d | | | |
| COIGS, F.O. BOX 001 w requires that the death certificate been signed by the attending phys should be detached for use as the | | | also en also esta esta esta esta esta esta esta esta | | | |
| onding use | Physician/Med | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal deatl | h 2 5 to 2 to 2 to 2 to 2 to 2 to 2 to 2 | | 23d. Date of delivery |
| death death death death | icia | in the past 12 months? 1 □ Yes 2 □ No | 4 Pregnant at time of death | h 3 Ectopic pregnancy 5 Other (specify) | | Month Day Year |
| by the ache | hys | 9 Unknown | 9□ Unknown | | | |
| es tha igned | by P | Part II. Other significant conditions | contributing to death but not resulting | in the underlying cause given in Part I. | 23e. Did tobacco | use contribute to the cause of death? |
| w require been sig should b | | | | | 1 ☐ Yes 2 | 2 □ No 3 Probably 4 □Unknown |
| law reas bec | piet | | | | 24a. Was an autopsy | 24b. Were autopsy findings available prior to completion of cause of |
| The law requires that the the law seen signed by the bage 2 should be detached. | Completed | | | | performed? 1 ☐ Yes 2 20 N | death? |
| | 0 | 25. Was case referred to medical | | 26. Place of Deat | h (Check only one) | |
| OI VITA Physicien: rthis certific ral director, | To B | examiner? 1 Tes 2 No | Hospital: 1 ☐ Inpatient 2 ☐ ER/O | Outpatient 3 DOA Other: 4 Nursing Ho | me 5 🗆 Residence | 6 ☐Other (Specify) |
| | | 27. Manner of Death | | Time of 28c. Injury at Injury Work? | 28d. Describe how inju | ury occurred |
| INVISION I or Attending after death. Director: After in by the fune | atic | 2 ☐ Accident investigat | ion | M 1 Yes 2 No | | |
| r Att | Certification; | 3 Suicide 6 Could not 4 Homicide determine | | farm, street, factory, office | 28f. Location (Street a City or Town, Sta. | and Number or Rural Route Number, te) |
| ital o | | | | | | |
| DIVISIO To the Hospital or Attendi within 24 hours after death, To the Funerel Director: A completely filled in by the fu | edical | (Check only 2 Medical Ex | aminer: On the basis of examination a | ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur | and due to the cause(red at the time, date ar | s) and manner as stated. nd place, and due to the cause(s) |
| the Itin 24 the F | Medi | one) | and manner stated. | | | ate signed (Month, Day, Year) |
| To the within To the comple | 2 | 29b. Signature and title of certifier | Maximil 10 | 29c. License number | | |
| | | | 17/1/Water 10/3 | 1/65/2 | 2 | 11.2.06 |
| | | 30. Name and address of person wh | to completed cause of death (Item 23a) | | (M) 7 | 1600 |
| سيني | 24 | 31. Date filed (Month, Day, Year) | 32. Registar's Signature | mars were, custon | 1100 4 | UUI |
| Regi | State strar | NOY 0 | 8 2006 Mens | B. Spelle | | |
| | | | | ~ / | | |

| Physici | an | 1. Decedent's Name (First, Midd. | • | | | | | | 2. Date of Deat Month | Day | Year | 3. Time o | |
|---|-------------------------------|---|---|----------------------------------|------------------------|--|------------------------------------|--------------|----------------------------------|-----------------------------|---|------------------------------------|---------------------|
| /Medi | | | | A MARIE | KELLY | | | | November | 9, 2 | | 9:12 | P M |
| Examir | er | 4a. Facility Name (If not institution St. Catherine's | _ | | | 4b. City, Town | n, or Location of | of Death | | | inty of Dea deric | | |
| Eugaral | | 5. Social Security Number | | 7. Age (In yrs. | last birthday) | If Under 1 Ye | ar If Under | | 8. Date of Birth (Month, Day, | | | thplace (State ountry) | or Foreig |
| Funeral Director | | 083-32-2220 Usual Residence of Decedent | 1□M 2□F | | 92 Yrs. | Months Day | ys Hours | Min. | May 28 | 1914 | New | Jersey | |
| nylanc how | | 10a. State 10b. County | , | 10c. Cit | y, Town or Lo | cation | | | | | | 10d. Inside C | • |
| Ba-f e | cto | Maryland Fred | erick | Thu | rmont | | | | | | | | s 2∏Ne |
| with the | Dire | 10e. Street and Number 13515 Graceham | Dood | | | 10f. Zip Cod | e 788 | | 1 | 0g. Citizen | | - | |
| eath v | era | 11. Marital Status | 12. Was Dece | dent Ever in II | S 13 1 | | | nin? (Sne | cify Yes or No- | | U.S.A | A . erican Indian, | |
| be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or iteme 23a or 28a-f ehow event, the Mydical Exarring must be coulfied at | Completed by Funeral Director | 1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorced | ried 1 Yes | ces? 2 🔼 No e | | Was Decedent of If Yes, specify C 1 ☐ Yes 2X 1 | | , Puerto I | Rican, etc.) | E | Black, Whi | | |
| 72 hou | ted | | nt's Education | | 16a. Dece | dent's Usual Oc kind of work do | cupation | t of working | 20 | 16b. Kind o | | | |
| ithin 7 | npie | Elementary/Secondary (0-12) | Callege (1- | -4or 5+) | life. i | DO NOT use rei | tired) | OI WOIKII | <i>'</i> 9 | | | | |
| e filed w al Hygier other th | ပ္ပ | 8 17. Father's Name (First, Middle, | / act) | | | Homemak | | r'a Nama | (First, Middle, N | Own | | | |
| ntal Hed of | Be c | Raymond Secor | Last | | | | 1 | | e Shu | naideil Sull | iailie) | | |
| should be nd Menta marked matic ev | 2 | 19a. Informant's Name/Relations | ship (Type, Print) | | 19b. Mailir | ng Address (Stre | | | l Route Number, | City or To | wn, State, | Zip Code) | |
| nd 2 salth ar 27 le | | Kathleen Cogan | / Daughter | - | | - | | | urmont, | - | | . , | |
| permit. Pages 1 and 2 should be Department of Health and Menla Important: If item 27 Is marked any injury or other treumatic es once. | | 20a. Method of Disposition 1 Burial 2 Cremation | 3 □Removal from S | 20b. F | emetery, crer | esition (Name of matory or other) | olace) | | | | | Town, State | |
| artme ortan injury | | ' 4 □ Donation 5 □ Other (5 | | l Ua | 22 | Cemete Name and Ad | dress of Facilit | 1/15 y | | yack, | | | |
| Depa Depa Impo any ir | | Rutex | \ au | - | RO | BERT E. | DAILEY | 7 & S | ON FUNE | RAL H | OMES, | P.A. | |
| | | 23a. Part1. Enter the disease, o shock, or heart failure. Lis | r complications that ca | used the deat | h. Do not ent | er the mode of | dying, such as | cardiac o | r respiratory arre | est, | 21700 | Approxima Interval Be | ite stween |
| Pnysician | | Immediate Cause (Final disease or condition | En | 1870 | ire | Ala | cher | rue | λ. δ | | | Onset and | |
| /Medical Examiner | | resulting in death) | Due to (| or as a conseq | uerce of): | | | | | | | | |
| Examiner | _ | Sequentially list conditions, | b | | | | | | | | | | |
| led nsit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | 1 00 00 00 | or as a conseq | derice oi). | | | | | | | | |
| al-trai | xar | that initiated events resulting in death) Last | c. Due to (| or as a conseq | uence of): | - | | | | | | | |
| sate be executed obysician and the burial-transit | ical | | d | | | | | | | | | | |
| rtificat ng phy as th | Aedi | IE ECMAN E | | | | | | | | | | | |
| ie death certificate be executed the attending physician and hed for use as the burial-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No | | rth 2 ☐ Feta ant at time of d | I death 3 | Ectopic pregna Other (specify | | | | | Date of de Month | livery Day | Year |
| ÷ > 5 | Phy | 9 ☐ Unknown Part II. Other significant conditi | | | ulting in the w | ndorhina sausa | avos is Bast I | | 23e Did tob | 2000 1160 0 | ootribute t | o the cause of | death? |
| law requires that as been signed b 2 should be deta | ed by | ratt ii. Other significant conditi | one contributing to de | atti but not res | unding in the d | nderlying cause | given in rait i | | 1 🗆 Ye | 1_ | | | Unknow |
| The law nate has be page 2 shi | Completed | | | | | | | | 24a. Was ar autops perform | y ned? | Ib. Were a prior to death? 1 \(\sum \section \) Yes | utopsy findings completion of o | availab cause of |
| ician: T certifical rector, p | 0 | 25. Was case referred to medica | al | | | | 26. Place | of Death | 1 ☐ Yes 2 | B) | - 10 100 | 2010 | |
| ys Si is | To B | examiner? 1 □ Yes 2 No | | | ER/Outpatier | nt 3□ DOA | Other: 4X Nu | rsing Hor | ne 5 🗆 Reside | nce 6 🗆 | Other (Spe | ecify) | |
| | | 27. Manner of Death ZNatural 5 ☐ Pendi | ng 28a. Date o | f Injury h, Day Year) | 28b. Time of Injury | | york? | | 28d. Describe ho | w injury oc | curred | | |
| Attending r death. ector: After by the fune | cati | 2 Accident invest | not be | -flating Ash | | | Yes 2 | | 28f. Location (Str | rant and the | umbar an O | west Basse Abo | |
| after all in by | ertification: | 4 Homicide determ | nined 289. Place buildir | ng, etc. (Specif | y) | eet, factory, offi | Ce | ľ | City or Town | | INDEE OF A | urar Aoute ivur | nuer, |
| To the Hoepitel or Attenwithin 24 hours after deatl To the Funerel Director: | edical Co | 29a. Certifier 1 Certifyi (Check only 2 Medical | ng Physician: To the Exeminer: On the ba and mann | sis of examina | wledge, death | h occurred at the vestigation, in m | e time, date an ny opinion, dea | d place, a | and due to the ca | iuse(s) and ate and plac | manner a: ce, and dur | s stated. e to the cause(| s) |
| To the within 2 To the comple | Med | 29b. Signature and title of certific | | o. stateu. | | 29c. Lic | ense number | | 1 25 | 9d. Date sig | ned (Mon | th, Day, Year) | |
| - s + ō | | Bouter | TKhan | 1828- | But | 200 | Itaar | +40 | >2 | 11/0 | 29/2 | 2006 | |
| | | 30 Name and address of person | who completed cause | e of death (Item | n 23a) (Type, | Print) | -100 | 7 | 4-12 | 30 | U. 4 | uain. | 57 |
| Ú | | | 1 00 | // | () | 17/5 | 111)(| 1 | _ | | | 1.5 | 171 |
| 0 | | 31. Date filed (Month, Day, Year |) 32. P | gistrar's Signa | - pos | 10/10 | 7 | | Muni | 1500 | ug | WV | -1 |

| | | | 1 - For State Registrar | State o | f Marylar | • | artment rtificate | | | and M | - | giene Reg. Ne | 200 | 6 | 37699 |
|--------------------------------|--|---------------|---|--------------------------|--|--|---|-----------------------------|----------------------------|-----------------|-----------------------------------|----------------------|----------------------------|----------------------|-------------------------------------|
| | Physici | an | 1. Decedent's Name (First, Middle, Las | t) | | | | | | | 2. Date of De Month | Da | | 'ear | 3. Time of Death |
| | /Medic | al | John Lee Kinsey 4a. Facility Name (If not institution, give | street and nu | mbarl | | 4b Ciby 1 | Four or | Location of | of Dogsth | Novemb | | 7, 200 County of | | 8:55 A M |
| | Examir | ier. | 718 Rosewood Road | | noer) | | Seven | | Location | n Dea(ii | | | nne A | | dol |
| | Funeral | | 5. Social Security Number 6. Se | ex. | 7. Age (In yrs. | last birthday) | If Under Months | | If Under | 24 Hrs. Min. | 8. Date of Bir | rth | | | place (State or Foreign |
| | Director | | 5/8-16-5815 | ŽM 2□F | 81 | Yrs. | Wioning | Days | 110013 | | Month, De | 9, 1 | | | ginia |
| | ow and | | Usual Residence of Decedent 10a. State 10b. County | | 10c. Ci | ty, Town or Lo | ocation | | | | | | | 1 | I Od. Inside City Limits |
| | a-fsh | ctor | Maryland Anne Ar | undel | Se | vern | | | | | | | | | 1 ☐ Yes 2 🛣 No |
| | or 28 | Director | 10e. Street and Number | | | | 10f. Zip | Code | | | | 10g. Ci | tizen of Wh | at Cour | ntry? |
| | s 23a | | 718 Rosewood Road | 10 Was Door | edent Ever in U | 16 121 | 211 | | | ~i=2 /C= | | | ted S | | |
| " | fter de r Item | Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married | Armed Fo 1 ☐ Yes | rces? 2 🕅 No | | _ | | n, Mexican | n, Puerto | ecify Yes or No Rican, etc.) |)- | | White, | |
| 903 | 72 hours after death with the Maryland natural; or Items 23a or 28a-f show Jical Essail sermast be notillied all | by | 3 M Widowed 4 □ Divorced | If Yes, Giv Year or D | re ates: | | 1 🗌 Yes 2 | .⊠ No | Specify: | | | | Specify: | Whi | te |
| 15-0 | | Completed | 15. Decedent's Ed (Specify only highest grad | | | 16a. Dece (Give | dent's Usua kind of wor DO NOT us | l Occupa k done d | tion uring most | t of work | ing | 16b. K | (ind of Busi | ness/Inc | dustry |
| 12 | filed within Hygiene. ther than " ent, It e Me | omp | Elementary/Secondary (0-12) | College (1 | -4or 5+) | Sales | | o rounou, | | | | Gr | cocery | St | ore |
| b | it the | BeC | 17. Father's Name (First, Middle, Last) | | | | | | 18. Mothe | r's Name | e (First, Middle | | | | 010 |
| yla | should be nd Mental marked o | 2 | Walter Kinsey | | | | | | | | mpsey | | | | |
| Mar | s 1 and 2 should Health and Men tem 27 Is marke othar traumatic | | 19a. Informant's Name/Relationship (7 Robert Kinsey / S | урв, Print) | | | | | | | ern, M | | | ite, Zip | Code) |
| ē, | is 1 and 2 of Health a item 27 is other train | 1 | 20a. Method of Disposition | | | Place of Dispo | sition (Nam | e of | 1 | | Date Page 1 | | ocation - Ci | ty or To | own, State |
| OE . | Page nent o int: If iry or | | 1 M Burial 2 □ Cremation 3 M '4 □ Donation 5 □ Other (Specify | | State | irfax M | | | · | 1/1: | 1/2006 | Fai | irfax, | , Vi | rginia |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 Department of F Important: If ite any injury or ot once. | | 21. Signature of Furieral Service Licen | S00 | , | 22 F: | . Name and | Addres | s of Facilit | у | meral l | Home | | | |
| | <u>0</u> 0 = € 0 | | 23a. Part1. Enter the disease, or comp | dications that o | M009 | 56 9 | 902 Br | add | ock R | oad, | Fairfa | ax, | VA 22 | 032 | Approximate |
| ı. | Dhusisian | | shock, or heart failure. List only of Immediate Cause (Final | one cause on e | ach line. | | | | , such as | cardiac | л төзрпасогу а | rrest, | | | Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) | u | ESTIVE (or as a consec | | FAILUI | KE. | | | | | | | 2 MONTHS |
| 1 | Examiner | L | Sequentially list conditions. | b | | | | | | | | | | | |
| Т | uted I Insit | Examiner | Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to | or as a consec | quence or): | | | | | | | | | |
| oʻ | be executed sician and burial-transit | Еха | that initiated events resulting in death) Last | Due to | or as a consec | quence of): | | | | | | | | - | |
| 8760, | hy: | edical | | d | | | | | | | | | | | |
| 9 x | eath certific attending p | /Med | IF FEMALE: | 23c. If yes, out | come of pregn | ancy | | | | | | | 23d. Date of | of dollars | 2007 |
| Box | death e atter d for L | Physiclan/M | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No | 1□Live b 4□Pregn | irth 2 ☐ Feta ant at time of c | aldeath 3□ | Ectopic pre Other <i>(spe</i> | | | | | | Month | | Day Year |
| P.0 | that the de ed by the detached | Phys | 9 🗆 Unknown | 9□ Unkno | | | | | | | | | | | |
| ds, | signed d be d | by | Part II. Other significant conditions co CIRRHOSIS OF LIVER | | | | | | n in Part I. | | | | | | ne cause of death? |
| Vital Records, | w requir been si should | Completed | CHRONIC BRONCHITIS | | | | | - | | | 24a. Was | | | | psy findings available |
| Re | The la | ошь | | | | | | | | | autor | | prio | r to cor th? | mpletion of cause of |
| ital | | BeC | 25. Was case referred to medical examiner? | | | | | | | | (Check only o | опе) | | | |
| of V | diis | ၉ | 1 ☐ Yes 2 ₹ No | | npatient 2 | | | | | | me 5 🎇 Resi | | | Specify | y) |
| ono | ding h. After funei | tlon | 27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date (Mont | th, Day Year) | 28b. Time of Injury | M | 3c, Injury Work 1 □ Y | at ? ′es 2.∐1 | | 28d. Describe | now inju | ry occurred | | |
| Division | or Attenater death | ertification; | 3 Suicide 6 Could not be determined | 28e. Place | of Injury - At h | ome, farm, str | eet, factory, | office | | | 28f. Location (. City or Tox | | | or Rura | l Route Number, |
| ā | spital or A ours after naral Dire filled in by | O | | Dana | 119, 010. (0)000 | ······································ | | | | | | , Olute | | | |
| | 4 T J & | edical | 29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam | iner: On the ba | best of my kno asis of examina ner stated. | owledge, death ation and/or inv | n occurred a vestigation, | it the tim in my op | e, date and inion, deat | d place, a | and due to the ed at the time, | cause(s) date and |) and mann d place, and | er as st I due to | ated. the cause(s) |
| | To the within 2 To the complete | Me | 29b. Signature and title of certifier | | 0 | | 29c. | License | number | | | 29d. Da | te signed (/ | Aonth, I | Day, Year) |
| | δ | | · /// | 41 | ND | | | 0295 | 571 | | | Nove | ember | 7, | 2006 |
| • | | | 30. Name and address of person who can Paul Berez, M.D. | | e of death (Iter Defense | | | roft | on - | MD 2 | 1114 | | | | |
| | Sta | te | 31. Date filed (Month, Day, Year) | | enstrar's Signa | | | | | | | | | | |
| | Registr | ar | NOV 0 9 | 2006 | A POPLAN | 10. | 1 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | • | For State of Maryland / State of Maryland / Registrar | Certific | | | | ene 9. No) 006 | 37700 |
|-------------------|---|----------------|--|---|---|--|---|--|---|
| - | Physicia | | 1. Decedent's Name (First, Middle, Last) | | | | 2. Date of Death Month Nov. 10 | | 3. Time of Death |
| | /Medic | al . | In Ik Kim 4a. Facility Name (If not institution, give street and number) | 4h (| City Town o | r Location of Death | NOV. 10 | , 2006 4c. County of De | 11:31a M |
| | Examin | er | Holy Cross Hospital | 45. | | er Sprir | ng | Montgor | |
| | Funeral | # | 5. Social Security Number 6. Sex 7. Age (In yrs. last | | nder 1 Year | | 8. Date of Birth | 9. B | irthplace (State or Foreign |
| H | Director | | 220-43-6408 ¹ ₹ ^{M 2□ F} 73 | Yrs. | Dayo | 7,0010 | 10/197 | 1933 K | orea |
| | and ww | | Usual Residence of Decedent 10a. State 10b. County 10c. City, To. | own or Location | 1 | | | | 10d. Inside City Limits |
| | Maryl -f sho | ţō | MD Montgomery Silv | ver Sp | ring | | | | 1 □Yes 2 XNo |
| | rh the | Director | 10e. Street and Number | 10 | f. Zip Code | | 10 | g. Citizen of What | Country? |
| | leath with the Marylan ns 23a or 28a-f show must be notified at | ral | 531 Randolph Road #333A | 140.111 | 2090 | | - the Ware and Na | USA | nerican Indian, |
| 21215-0036 | s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygene. I then 27 is marked other than "ratural", or items 23a or 28a-f show item 27 is marked other than "ratural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: | | es 2 XNo | lispanic Origin? (Spe an, Mexican, Puerto Specify: | ecity Yes of No- Rican, etc.) | Black, Wi | |
| 2-0 | 72 ho 'natur dical | Completed | 15. Decedent's Education (Specify only highest grade completed) | 6a. Decedent's | Usual Occup of work done | oation during most of worki d) | ing | 16b. Kind of Busines | ss/Industry |
| 121 | within iene. than "I | ldmo | Elementary/Secondary (0-12) College (1-4or 5+) | | | " Retail | | Clothi | ng |
| 9 | filed Hygie Sther ent, th | | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Name | (First, Middle, N | faiden Surname) | |
| lan | ould be i Mental larked o | To Be | Sook Shin Kim | | | | eo Kim | | |
| Maryland | s 1 and 2 should I of Health and Men item 27 is marker other traumatic | | 19a. Informant's Name/Relationship (Type. Print) Hung Cha Kim/Wife | | | and Number or Rura ph Rd #3 | 333A Si | lver Sp | |
| Baltimore, | 0 0 - | | 20a. Method of Disposition 1 XBurial 2 Cremation 3 Femoval from State 4 Donation 5 Other (Specify) | e of Disposition letery, cremator Ce of H | (Name of y or other pla leavel | n 1 1/13 | | Silver S | or Town, State pring, Md |
| Balt | permit. Pag Department Important: I any Injury o | | 21. Signatural Funeral Service Courses | 9241 | Col | | vd.Silv | ver Spri | CE, P.A. ng, Md20910 |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. | Do not enter the | mode of dyi | ng, such as cardiac | or respiratory arre | est, | Approximate Interval Between Onset and Death |
| 1 | Physician | | Immediate Cause (Final disease or condition a. Acute res | pirato | | | | | 4 |
| | /Medical Examiner | | Due to (or as a consequer Congestive | | t fai | luro | | | |
| | A | ē | Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury End stage | | c rar | TUIC | | | |
| | outed id ansit | Examine | that initiated events c. | | dise | ase | | | |
| 90, | ie exe cian ar urial-t | EX | resulting in death) Last | nce of): | | | | | |
| 68760, | ficate be executed physician and is the burial-transit | edical | d | | - | | | | |
| Box | ath certi | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnanc 1 □ Live birth 2 □ Fetal dt 4 □ Pregnant at time of deat 9 □ Unknown | eath 3⊟Ecto | opic pregnanc er <i>(sp</i> ec <i>ify)</i> _ | ry | | 23d. Date of Month | delivery Day Year |
| P.0 | ires that the de signed by the a be detached t | y Ph | Part II. Other significant conditions contributing to death but not resulting | ng in the underly | ying cause gi | ven in Part I. | 23e. Did tot | pacco use contribute | e to the cause of death? |
| rds | quires an sign uld be | ed by | pneumonia | | | | 1 □ Ye | es 2 No 3 | Probably 4XJUnknown |
| or Vital Records, | aw requir is been si 2 should | Completed | | | | | 24a. Was a | n 24b. Were | autopsy findings available to completion of cause of |
| I R | The lav ate has page 2: | Com | | | | | perform 1 Yes | med? death | i? res 2□No |
| /ita | cian: ertific ector, | Be | 25. Was case referred to medical examiner? Hospital: Hospital: | | Ot | 26. Place of Deather: | | | |
| or | Physician: r this certific ral director, | 2 | T res 2 No T inpatient 2 LEF | R/Outpatient 3 8b. Time of | L BOX | 4 Linursing no | | ence 6 Other (Sow injury occurred | pecify) |
| On | Attending r death. sctor: After by the funer | tion | 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation | Injury A | 28c. Inju Wo /I 1 | rk?]Yes 2∐No | | | |
| Division | l or Atten after deat Director d in by the | Certification: | 3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of injury - At home building, etc. (Specify) | e, farm, street, f | actory, office | | 28f. Location (St City or Town | treet and Number or n, State) | Rural Route Number, |
| | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page. | Medical C | 29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge of the page of examination and manner stated. | edge, death occ on and/or investi | curred at the gation, in my | ime, date and place opinion, death occu | , and due to the c rred at the time, d | ause(s) and manne late and place, and | r as stated. due to the cause(s) |
| · c | To the within 2 To the complex | Me | 29b. Signature and title of certifier | 11/ | | se number 2261 | | Nov. 10, | |
| | V | | 30. Name and address of person who completed cause of yeath (Item 2 Alan R. Segal MD 1500 F | 23a) (Type, Print orest | Glen | Rd Silve | er Spri | ng,Md 20 | 0910 |
| 10 | St Regist | ate rar | 31. Date filed (Month, Day, Year) NOV 1 3 2006 32 Tegistrar's Signatu | re | W | | | | |

State of Maryland / Department of Health and Mental Hygien & UUD 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 8:15 P M 2006 Jannie Florence Kennedy November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Forestville Nursing Home Forestville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 XF Yrs. Director 94 Aug. 10, 1912 South Carolina 251-36-8694 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland. Department of Heelth and Mental Hygiene. Importent: If I tem 27 is marked other then "natural" ~ ... any fully or other traumatic even. 10c, City, Town or Location 10d. Inside City Limits 10a State 10h Counts 1 □XYes 2 □ No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 - 58th St., NE 20019 United States by Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married African 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6th Domestic Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Glenn Mable Boozer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20748 Betty Jordan/Niece 4209 Weldon Dr., Temple Hills, MD 20b. Place of Disposition (Name of cemetery, crematory Methy), plapeark 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/13/2006 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary failure Wash., DC 20019 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ettending physicien end for use as the burial-transit Hypertension Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? Yes 2 No certificate 2 No 1☐ Yes 1 Tyes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other ၉ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ۵ 4 Homicide 29a. Certifier 1 Xcertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 9, 2006 D51520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern Ave., SE #310, Washington, DC 20032 Bahram Pishdad 31. Date filed (Month, Day, Year) NOV 1 3 2006 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

| | | riedse | State of Maryland | | | | _ | • | |
|--|----------------|---|---|---|--|---|---|---|-------------------------------------|
| | | For State | Otate of Marylant | | rtificate of l | | | Beg. NG: 006 | 37702 |
| 4 | | Registrar 1. Decedent's Name (First, Middle, La | st) | | | | 2. Date of De. | | 3. Time of Death |
| Physici | | NANCY | MARIE LA | AWRENC | E | | Month | Jay 7 Zuch | 17024 |
| /Medic Examin | _ | 4a. Facility Name (If not institution, giv | | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 4b. City, Town, or | r Location of Dea | th | 4c. County of Dear | th |
| | To. | 8813 Clay | ton LAN= | | Clin | Tow | | Prince | 6 eogés |
| Funeral | | 5. Social Security Number 6. S | Sex 7. Age (In yrs. la | | If Under 1 Year Months Days | If Under 24 Hrs Hours Min | | y, Year) Co | hplace (State or Foreign ountry) |
| Director | | 563-48-8191 | 68 | Yrs. | | | May 3, | 1938 Texa | as |
| and and | | Usual Residence of Decedent 10a. State 10b. County | 10c. City | , Town or Lo | ocation | | | | 10d. fnside City Limits |
| Mary | ţo | Marriand Duines C | eorge's Clir | | | | | | 1 □ Yes 2 □ X No |
| r 28a | Director | Maryland Prince G 10e. Street and Number | eorge s CIII | ILOII | 10f. Zip Code | | | 10g. Citizen of What Co | ountry? |
| id Z 1 Z 1 2-0030 of filed within 72 hours after death with the Marylan of Hygiene other than "natural", or Items 23a or 28a-f show ont, the Mudical Exercit ar mast be notified at | | 8813 Clayton Lane | | | 20735 | ; | | U.S.A. | |
| dear | Funerai | 11. Maritaf Status | 12. Was Decedent Ever in U.S Armed Forces? | S. 13. | Was Decedent of H | lispanic Origin? (| Specify Yes or No | 14. Race - Ame Black, Whit | |
| S affer 2 | J. | 1 Never Married 2 Married | 1 ☐ Yes 2 👿 No ff Yes, Give | 1 | 1 ☐ Yes 2 ☑ No | Specify: | | Specify: | |
| hours | d by | 3 ☑ Widowed 4 □ Divorced 15. Decedent's E | Year or Dates: | 160 Dags | dent's Usual Occup | ation | | 16b. Kind of Business | iite |
| n 72 | Completed | (Specify only highest gra | ade completed) | (Give | kind of work done of DO NOT use retired | durina most of wo | orking | Tob. Kind of business | andustry |
| within the transfer of the tra | щo | Elementary/Secondary (0-12) | College (1-4or 5+) | Admi | nistrativ | re Assist | tant | Auto Repai | r Shop |
| ether the | BeC | 17. Father's Name (First, Middle, Last |) | | | | | , Maiden Sumame) | 21101 |
| ity ideas of the Naryland with the Maryland should be filed within 72 hours after death with the Maryland Marked by Hygiene. marked other than "natural", or items 23a or 28a-f ahow matic event, the Modical Exercit at mast be notified at | To B | Cecil T. Fant | | | | Lola B | elle Mead | lor | |
| ie, intal yidalid x12.13-0030 s 1 and 2 should be filed within 72 hours after death with the Maryla Fleath and Mental Hygiene Heath and Heath and Mental Hygiene items 23a or 28a-f ahov item 27 is marked other than "natural", or Items 23a or 28a-f ahov other traumatic event. The Mudical Exercit er in all be notified as | | 19a. Informant's Name/Relationship (| Type, Print) | 19b. Maili | ng Address (Street | | | er, City or Town, State, | Zip Code) |
| and and and and and and and and and and | | Larry A. Lawrence | | | | ove Cour | | andria,VA 2 | |
| Datificate, IV permit. Pages 1 and Department of Heatth Important: If item 27 any Injury or other tr | | 20a. Method of Disposition 1 Buriaf 2 Cremation 3 E | | ace of Dispo emetery, cre | osition (Name of matory or other plac | ce) | Date | 20c. Location - City or | Town, State |
| Pages Iment of tant: If it jury or o | | 4 Donation 5 Other (Special | | ockmo | rton Ceme | tery 1 | 1/14/06 | Throckmort | on, Texas Funeral Home |
| Dallill permit. Pa Departmen Important: any Injury | | 21. Signature of Funeral Service Lice | 1500 | 2: | 2. Name and Addres | ss of Facility M1 | urphy Fal | lls Church | Funeral Home |
| a durad | | Janus 1. | fei | Do not on | 102 W. Br | oad St, | Falls Cl | nurch, VA 2 | 2.046 Approximate |
| | | 23a. Part1. Enter the disease, or com- shock, or heart failure. List only fmmediate Cause (Final | one cause on each line. | i. Do not en | ter the mode or dyin | e . | 10 or respiratory a | L T | Interval Between Onset and Death |
| Physician /Medical | | disease or condition resulting in death) | a Attensel | mil! | e Capal | with a | yar M | En Disea | |
| Examiner | | | Due to (or as a consequ | Jence of): | | | | | |
| | ē | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as a consequ | uence of): | | | | | |
| uted | Examiner | Cause (Disease or injury that initiated events | C | | | | | | |
| rou, te be executed ysician and e burial-transit | | resulting in death) Last | Due to (or as a consequ | uence of): | | | | | |
| wrequires that the death certificate be executed wrequires that the death certificate be executed been signed by the attending physician and should be delached for use as the burial-transit | icai | (| _ d | | | | | | |
| The law requires that the death certifica The law requires that the death certifica ate has been signed by the attending phy page 2 should be delached for use as in | Physician/Med | IF FEMALE: | | | | | | | |
| ath cer attendir | lan/ | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnar | death 3[| Ectopic pregnancy | , | | 23d. Date of de Month | fivery Day Year |
| the de | /sic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4☐Pregnant at time of de 9☐Unknown | eath 5 | Other (specify) | | | | , |
| that the by detac | Ph | Part fl. Other significant conditions | contributing to death but not resu | ulting in the u | inderlying cause giv | en in Part f. | 23e. Did t | obacco use contribute to | the cause of death? |
| w requires to been signed should be a | d by | | _ | | , , , | | 10 | Yes 2□No 3□P | obably 4- Unknown |
| w requ | Completed | | | | | | 24a. Was | an 24h Were a | utopsy findings available |
| he lay | ğ | | | | | | autoj perfo | prior to death? | completion of cause of |
| VICAL DEC Sician: The law certificate has b irector, page 2 s | e C | 25. Was case referred to medical | | | | 26 Place of De | 1 ☐ Yes eath (Check only o | | ; 2□ No |
| ysicia s cert direct | To B | examinar? | Hospital: | ER/Outpatie | nt 3 DOA Oth | 00 | | dence 6 ☐Other (Spe | cify) |
| VISION OF VICE Attending Physician: r death. ector: Atter this certific by the funeral director, | | 27. Manner of Death | 28a. Date of fnjury (Month, Day Year) | 28b. Time o | | y at | | how injury occurred | |
| JIVISION or Attending after death. Director: Attention by the fune | atio | 1 Natural 5 Pending 2 Accident investigation | on | mjary | | Yes 2 □No | | | |
| r Atte | Certification; | 3 ☐ Suicide 6 ☐ Could not be determined | | | reet, factory, office | | 28f. Location (City or To | Street and Number or R wn, State) | ural Route Number, |
| ral D | Se | | | | | | | | |
| To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | edical | (Check only 2 Medical Exa | hysician: To the best of my know miner: On the basis of examinat | wledge, deal tion and/or in | th occurred at the tire evestigation, in my o | me, date and place pinion, death occ | ce, and due to the curred at the time, | cause(s) and manner as date and place, and due | s stated. e to the cause(s) |
| ro the vithin 2 Fo the comple | Med | 29b. Signature and title of certifier | and manner stated. | | 29c. Licens | e number | | 29d. Date signed (Mont | h Day Year) |
| F. 3 F. 8 | | 100 | Mations | | e.Lo | 065500 | | Maria | C |
| 6 | | 30. Name and address of person who | completed cause of death (from | 1 23a) /Tuna | Print) | 17571 | h/ 1 | 100 Chlor | 7 2006 |
| ` | ĺ | CALVADOV S. / | NOT IN BOOK A | tosa. | tal Dr. | re c | Leve 0 | Prince | 6 was |
| Sta | ate | 31. Date filed (Month, Day, Year) | 2. Registrar's Signar | ture | | 7 | 0 | , , , , , | Jes |
| Regist | | NOV 1 3 20 | 106 France St | A STATE OF | alis) | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene 115

| 3 | 7 | 7 | 0 | 3 |
|---|---|---|---|---|
| | - | | | |

| | | | 1 - State of Maryland / Department of Health and Certificate of Death | | Reg. | | 31103 |
|-------------------|--|---------------------|--|-------------------------------------|---------------------------------|---|--|
| | Physici | an | Decedent's Name (First, Middle, Last) | 2. Date Mont | 1 | Day Year | 3. Time of Death |
| | /Medi | | MARK STEPHEN LARSON | OCT | | , 2006 | 1362 M |
| | Examir | ner | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De | eath | | 4c. County of Death | EDV |
| | | | Montgomery General Hospital Olney | | | MONTGOM | |
| | Funeral Director | | 5. Social Security Number 2 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 F S1 Yrs. Wonths Days Hours W | Min. 8. Date (Mont | of Birth h, Day, Ye • 22 | ar) 9. Birthp Cour 1954 Wa | lace (State or Foreign http). Sh. DC |
| | and w | | 10a. State 10b. County 10c. City, Town or Location | | | 1 | 0d. fnside City Limits |
| | Mary | ō | MD Montgomery Silver Spring | | | | 1 ☐ Yes 2 ☐ No |
| | 28s | rec | 10e. Street and Number 10f. Zip Code | | 10a | Citizen of Whaf Cour | atry? |
| | a 23a or | erai Di | 3973 Wendy Lane 20906 | | | U.S. | A. |
| 21215-0036 | be filed within 72 hours after death with the Maryland nial Hygiene. bd other then "natural", or tiems 23s or 28s-f show event, the Madical Examinar must be notified at | by Funeral Director | 11. Marital Status 1 □ Never Married 2√2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No Specify: 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Putters, Give Year or Dates: | 7 (Specify Yes o | or No- :.) | 14. Race - Americ Black, White, Specify: Wh | |
| 5 | 72 h | Completed | 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of | workina | 16b. | Kind of Business/Inc | Justry |
| 2 | hen. | ш | Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired) | . | | | |
| 2 | e filed withing Hygiene. I other then vent, the M | | 12th Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) | | | | |
| anc | a la b | Be | | Name (First, M | | | |
| <u> </u> | 2 should be f and Mental b le marked of aumatic ave | 2 | Eugene Larson | Marjo | | | |
| Maryland | 7-1-2 | | 19a. Informant's Name/Relationship (Type, Print) Edna Larson (Wife) 19b. Mailing Address (Street and Number or 3973 Wendy Lane, | | | | |
| စ် | s 1 and 2 if Health item 27 I | | 20a. Method of Disposition 1 ORBurial 2 Occupation 3 Demonstrator State 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | | Location - City or To | |
| Baltimore, | Page nent o | | 4 Donation 5 Other (Specify) Gate of Heaven Cem 1 | | Si | lver Spr | ing, MD |
| Bal | permit. Departr Importe any nje | | 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 22. Name and Address of | | | | |
| - 5 | | L | 23. Part1. Enter the distase, or complications that caused the down long on one enter the mode of dying, such as card shock, or heart failline. List only one cause on each line. | diac or respirati | ory arrest, | | Approximate Infervaf Between |
| | Physician | | Immediate Cause (Final disease or condition a Small Cell Lung Can | cer | | , | Onset and Death |
| | /Medical Examiner | | resulting in death) Due to (or as a consequence of): | | | | |
| | Laminer | _ | Sequentially list conditions, b. | | | | |
| | led sit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | |
| | ificate be executed g physician and as the burial-transit | хаг | that initiated events c. resulting in death) Last Due to (or as a consequence of): | | | | |
| 68760, | siciar buri | ai | | | | i | |
| 687 | ifficate g physias the | edicai | d | | | | |
| Вох | | | IF FEMALE: 23b. Was decedent pregnant 23c. ff yes, outcome of pregnancy | | | 23d. Date of delive | n. |
| Ď. | death e atte d for | Physician/N | in the past 12 months? 1 Ves 2 No 4 Pregnant at time of death 5 Other (specify) | | | | Day Year |
| P.0 | t the de by the a | hys | 9 ☐ Unknown 9 ☐ Unknown | | | | |
| | es tha igned i | by P | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. | Did tobacc | o use confribute to th | e cause of death? |
| of Vital Records, | w require been sig should b | | | _ | 1 De es | 2 □ No 3 □ Proba | abfy 4 □Unknown |
| ပ္စ | law re as be 2 sho | piet | | | Was an | 24b. Were autor | osy findings available |
| æ | The I | Completed | • | | autopsy performed es 2 24 | death? | npletion of cause of |
| i | iclan: certifica ector, p | Bec | 25. Was case referred to medical examiner? 26. Pface of D | 1 ☐ Y Death Check o | | 40 165 | 20140 |
| <u></u> | hysic his ce I dire | 2 | Hospital: | | 12. | 6 ☐Other (Specify |) |
| u u | Jing Ph J. After th funeral | ü | 27. Manner of Death 17 ■ Natural 5 □ Pending 28a. D to of Injury (Month, Day Year) 28b. Time of finjury 28c. finjury af finjury 28c. finjury 28c | 7 | | jury occurred | |
| Si Si | death. ctor: A the fu | cati | Accident investigation Suicide 6 □ Could not be | | | | |
| Division | or Al | Certification: | determined 4 Homicide 289. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) | 28f. Locat City o | on (Street r Town, Sta | and Number or Rural ate) | Route Number, |
| | To the Hospital or within 24 hours after To the Funeral Dir completely filled in | edicai C | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time data and place (Check only one). 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred to the control of the control | ans, and due to courred at the t | the cause | (s) and manner as sti | Mad. the cause(s) |
| | To the within 2 To the complet | Med | one) and manner stated. 29b. Signature and title of certifier 29c. License number | | | Date signed (Month, L | |
| | F 3 F 8 | | D47457 | | 00 | T 71 | 2 006 |
| (| 5 | | 30. Name and address of person the original feet cause of death (Item 23a) (Type, Print) CHTRA | ΔΙΔα | Dai | -1 4 | 1 2000 |
| | | | 18111 Prince Philip Dr. #327 Olney, MD | 201 | 337 | | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 1 3 2006 | ton | - C- | | |
| | , rogioti | | TO TO THE PARTY OF | | | | |

DHMH 17 Rev 1/2001

| | | | For State Registrar | State of Maryland | | | nt of He | | nd Me | | ene. | 006 | 37704 |
|------------|--|------------------|---|---|---------------------------------|------------|----------------------------|-----------------------|-------------|-----------------------------------|-------------|-----------------|--|
| , | | | 1. Decedent's Name (First, Middle, Last) | | | | | | 2 | Date of Death | Day | Year | 3. Time of Death |
| | Physicia /Medic | A. | Vendric Vardel | | - 1 | | | | | NOvembe: | _ | | 2:00p M |
| | Examin | er | 4a. Facility Name (If not institution, give st | | | , | Town, or Linto | Location of | Death | | | ounty of Deatl | |
| | | 爱 | Future Care Nursi 5. Social Security Number 6. Sex | 7. Age (In yrs. I | ast birthday) | | r 1 Year | If Under 2 | 4 Hrs. 8 | I. Date of Birth | | ince G | |
| | Funeral Director | | | M 2□F 57 | Yrs. | Months | | Hours | Min. | (Month, Day, Oct. 17 | Year) 19 | 49New | nplace (State or Foreign untry) Bern, N.C. |
| *2 | | | Usual Residence of Decedent | | | | | | | | | | |
| | how | _ | 10a. State 10b. County | | , Town or Loc | | . \ | ì | | | | | 10d. Inside City Limits TY Yes 2 ☐ No |
| | Se-f | cto | Maryland Prince Ge | eorges | ort u | 193 | Code O | Tox | | | | (140 . 5 | |
| | with the | 급 | 10e. Street and Number | DI | | 101. 21 | 07H | £b. | | 16 | • | ited S | · |
| | eath 1 | eral | 26/2 Kingsway 11. Marital Status |) O(+ 2. Was Decedent Ever in U.: | S. 13. V | | -/- | / | in? (Speci | fy Yes or No- | | I. Race - Ame | |
| 10 | r item | Funeral Director | 1 Never Married 2 Married | Armed Forces? 1 ☐ Yes 2 ♣ No | If | Yes, spe | cify Cubar | n, Mexican, | Puèrto Ri | can, etc.) | | Black, White | |
| 21215-0036 | 72 hours after death with the Maryland naturel; or Iteme 23a or 28e-f ehow Jisal Examiner must be molified at | þ | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | 1 | ∐ Yes | 28 No | Specify: | | | S | pecify: B. | lack |
| 5-0 | 72 ho natur | Completed | 15. Decedent's Educa (Specify only highest grade | | 16a. Deced (Give | kind of w | ork done d | uring most | of working | , 1 | 16b. Kind | d of Business/ | Industry |
| 21 | within then the Max | ldm | Elementary/Secondary (0-12) | College (1-4or 5+) | | | ise retired) | | | | Desi | na fo | |
| | e filed wall Hygiel other the | | 17. Father's Name (First, Middle, Last) | 4 | Acc | ount | 1116 | 18. Mother | 's Name (| First, Middle, M | | vate umame) | |
| Maryland | | o Be | Isaac N. Long | | | | | | , | atrice I | | | |
| IZ | 2 should band and Ment is marked eumatic e | 은 | 19a. Informant's Name/Relationship (Typ | e, Print) | 19b. Mailin | g Addres | s (Street a | nd Number | or Rural I | Route Number, | City or | Town, State, Z | Tip Code) |
| | and 2 ealth a m 27 is | | Shirley G. Hattor | n / Sister | 2612 1 | King | way R | d. Ft | . Was | shington | n. M | d. 20 | 744 |
| | as 1 an of Heal item? | | 20a. Method of Disposition | 20b. P | lace of Dispos emetery, crem | sition (Na | me of | | Dat | | | ation - City or | |
| Ë | Page nent ent: H ury o | | 1 ⊠Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) | Li | ncoln r | | | 1 | | | | land, l | |
| Baltimore, | permit. Pages 1 Department of H Importent: If Ite any injury or ot once. | | 21. Signature of Funeral Service License | wes MO108 | 5 22 | ATE 3 | nd Addres ander Mari | s of Facility boro | ope I | uneral Forest | Hom vill | es, P. | A·20747 |
| | ** | Г | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one | ations that caused the death | . Do not ente | er the mo | de of dying | , such as c | ardiac or | respiratory arre | est, | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | MODINS | - (| SCI | SAS | 2010 | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a consequ | uence of): | | | | | | | | |
| | Examine | _ | Sequentially list conditions, b. | Due to for as a consequ | | | | | | | | | |
| | ted Isit | Examine | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | - Due to (or as a consequ | derice or). | | | | | | | | |
| | axecur and al-trai | xar | that initiated events c. resulting in death) Last | Due to (or as a consequ | uence of): | | | | | | | | |
| 8760, | cate be executed obysician and the burial-transit | lcal 8 | d | | | | | | | | | | |
| Õ | tificat og phy as th | led | | | | | | | | | 1 | | |
| Вох | eath certific attending pi for use as t | an/A | 23b. Was decedent pregnant | lc. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal | | Ectopic p | pregnancy | | | | 23 | d. Date of del | ivery Day Year |
| | at the dea by the att tached fo | Physician/Med | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4☐Pregnant at time of de 9☐Unknown | eath 5□ | Other (s | pecity) | | | | | NOTATI | Day (Sa) |
| P.0 | hat th d by detach | | Part II. Other significant conditions cont | ributing to death but not resi | ulting in the ur | nderlyina | cause give | n in Part I. | | 23e. Did tob | acco us | e contribute to | the cause of death? |
| Records, | The law requires that the death certificate be executed sie has been signed by the attending physician and page 2 should be detached for use as the burial-transit | d by | 3 | • | | ,,,, | | | | 1 ☐ Ye | s 2 🕽 | No 3□Pr | obabiy 4 🗆 Unknown |
| 20 | v require been si should I | ete | | | | | | | | 24a. Was ar | n | 24b. Were au | itopsy findings available |
| Re | The lay | Completed | | | | | | | | autops perform | y ned? | prior to death? | completion of cause of 2□ No |
| Vital | ician: Th certificete rector, pag | 0 | 25. Was case referred to medical | | | | | 26. Place | of Death (| Check only one | | 10 165 | 20 100 |
| \geq | Physician: this certifice ral director, i | To B | examiner? 1 ☐ Yes 2 ☑ No | ospital: 1 Inpatient 2 | ER/Outpatien | t 3 🗆 🖸 | Othe | | | e 5 Reside | | □Other (Spe | cify) |
| ז סל | | | 27. Manner of Death 1X□Natural 5 □ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time of | | 28c. Injury Work | at | 28 | d. Describe ho | w injury | occurred | |
| Θ̈́ | Attending r death. | Satic | 2 Accident investigation | | | М | 10 | res 2□N | | | | | |
| Division | i i i te o | Certification; | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At he building, etc. (Specify | | eet, facto | ry, office | | 28 | 31. Location (Sti City or Town | | Number or Ru | ural Route Number. |
| ф | Hospital | | 29a. Certifier 1 Certifying Phys | ician: To the best of my kno | wledge death |) OCCUITE | d at the tim | e date and | diplace, an | nd due to the ca | use(s) a | nd manner as | stated |
| | To the Hospital within 24 hours a To the Funerel E completely filled | edical | (Check only 2 Medical Examin | er: On the basis of examina and manner stated. | tion and/or inv | vestigatio | n, in my or | inion, deat | h occurred | d at the time, da | ate and p | olace, and due | to the cause(s) |
| | To the within 2 To the complet | Me | 29b. Signature and title of certifier | | | 25 | c. License | number | ((00000 | | 9d. Date | signed (Monta | h, Day, Year) |
| | | | · MIT | | - | |)-1 | 85 | 75 | | NOve: | mber 9 | , 2006 |
| 0 | (5) | | / // | mpleted cause of death (Item | | | | | | 007 | . 1 | C 35. | |
| | | | Phillip Wisotsk | 22 Pagistrar's Signs | tura - | | Cen | cer D | r. S- | ·207 Wal | Ldor | r, Md. | |
| | St Regist | ate rar | 31. Date filed (Month, Day, Year) NOV 1 3 2006 | 32. Registrar's Signa | Speed | 5 | | | | | | | |

06-08379 John William Lucas

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

| | | 1- For State Registrar | | Certif | icate of | Death | | | Reg | No. | JUb | 3//0 |
|--|----------------|--|---|-------------------|--------------------------|---------------------------------------|----------------|------------|-------------------|-------------------|--|-------------------------|
| Physicia | an/ | 1. Decedent's Name (First, Middle | e,Last) | - | • | | | | Date of Death | Day Yea | .r | Time of Death |
| ledical Exami | ner | John Willia | | | | | | | Month lovember | | | 0229 hrs |
| | | 4a. Facility Name (if not institution | _ | | 4 | b. City, Town, o | r Location of | f Death | | 4c. County | | |
| . · | | Prince George's Coun | | | | Cheverly | | | | Prince C | • | |
| Funeral | | 1 | | e (In yrs. last I | oirthday) | If Under 1 Yes Months Day | | | | | 9. Birthpl: Foreign. | ace (State or DC |
| Director | | 579-90-0565 | 1 XM 2 F | 37 | Yrs. | I WORKING Bay | ys | | 03/25/ | 1969 | Colling | shington |
| ý | | Usual Residence of Decedent | | 10 0 | | | | | | | - | |
| w any | | 10a State 10b. County | | 10c. City, Tov | | | | | | | | od Inside City Limits |
| faryland 28a-f show I at once. | ō | MD PG | | Ca | pital | Heights | 5 | | | | | X Yes 2 No |
| Mary 28a- d at | Director | 10e. Street and Number | | | | 10f. Zip Code | | | 100 |). Citizen of Wh | nat Country | ? |
| th the Maryland 23a or 28a-f sho notified at once. | | 5600 Rollins La | ne | | | 207 | 743 | | | USA | | |
| t be n | Funeral | 11. Marital Status 1 Never Married 2 Ma | 12. Was Decedent Armed Forces? | Ever in U.S. | | Decedent of Hi | | | | 14. Race White | | Indian, Black, |
| r deal or it | F | | 1 Yes 2 | X No | | | | | | | | _1_ |
| hours afte 'natural'', Examiner | þ | | orced If Yes, Give Year or Dates: | | | Yes 2 X No | | | I | Specify | Blac | |
| hour "natu | Completed | Decedent's Education (Specific Elementary/Secondary (0-12) | College (1-4 or 5 | | | 's Usual Occupa st of working life | | | done | 16b. Kind of Bu | siness/inau | stry |
| 5-0036 led within 72 Hygiene other than ' | eld | 12th | College (1-4 of C | ,,, | Cust | comer Se | ervice | 2 | | Priv | zate | |
| -00 I with | ĕ | 17. Father's Name (First, Middle, | Last) | | Cub | | | | st. Middle. Ma | aiden Surname | | |
| 215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica | Be C | Robert Lucas | , | | | | Edi | | loore | | , | |
| ID 21215-00; should be filed within and Mental Hygiene 7 is marked other thatie event, the Men | .0 | 19a Informant's Name/Relationsh | nip (Type, Print) | -1 | 19b. Mailing | Address (Stre | | | | er, City or Tow | n, State, Zir | Code) |
| MD id 2 sho alth and in 27 is aumati | | Thomasine Lucas | - Wife | 1.0 | | Rollins | | | | | | 20743 |
| | | 20a. Method of Disposition | kommond | | | tion (Name of ce | emetery, | Da | ate | 20c. Location - | City or Tow | vn, State |
| Baltimore, Permit Pages ar Department of Hee Important: If ite | | 1 X Burial 2 Cremation | | ite | natory or other | | , | 11/11 | /2006 | Washir | aton | D C |
| Itin Dit Partme | - 1 | 4 Donation 5 Other Sp 21. Signature of Funeral Service | | Gren | | Cemetery ame and Addres | | | | | | |
| Balti permit Departir Imports injury | Į. | Overnon ne | Hoona | \mathcal{M} | | 01 Cleve | | | | | | 20737 |
| Physician | | 23a. Par I. Enter the disease, or | complications that caused | the death. Do | | | | | | | art A | Approximate Interval |
| /Medical | | failure. List only one cause | on leach line. a Complications of | f Gunshot | Wounds | | | | | | E | Between Onset and Death |
| xaminer | | Immediate Cause (Final disease or condition resulting in death) | Due to (or as a conse | | rroundo | | | | | | _ | |
| | | Sequentially list conditions, | b | | | | | | | | | |
| | ne | if any, leading to immediate cause. Enter Underlying Cause | Due to (or as a conse | equence of): | | | | | | | | |
| | Examiner | (Disease or injury trial initiated events resulting in death) Last | Due to (or as a conse | quence of): | | | | | | | - | |
| vecuted 1 and - transit | | | d | | | | | | | | | |
| e exercian a | n/Medical | UNPENDED | AMENDED | | | | | | | | | |
| 8760, ifficate be ex ng physician as the burial | Š | IF FEMALE: | 23c. If yes, outcon | ne of pregnance | | | - | | | 23d. Date of | delivery | |
| 687 ertific ding e as tl | an/ | 23b. Was decedent pregnant in the past 12 months? | I Live biltil | مالم مالم مالم | 2 Feta | al death 3 | Ectopic | pregnancy | | Month | Day | Year |
| Box 687 e death certifine the attending ed for use as t | Sic | 1 Yes 2 No 9 Unk | nown 9 Unknown | time of death | 5 Oth | er (Specify) | | | | - | | 8 |
| D. B. t the de by the ached f | Physiciar | Part II. Other significant conditi | | but not resul | ting in the ur | nderlying cause | given in Pari | 11 | 23e. Did tob | acco use contri | bute to the | cause of death? |
| , P.O. | ō | | | | 3 | , | 3 | | | | | y 4 Unknown |
| ords, w require s been sig | Completed | | | | | | | - 11 | 24a Was ar | 1 24b V | Vere autons | sy findings available |
| COFC law re has be | 읦 | | | | | | | | autopsy | / p | | pletion of cause of |
| Rec The I | 칭 | | | | | | | | 1 Yes 2 | | ✓ Yes | 2 No |
| tal Rec cian: The certificate ector, page | Be (| 25. Was case referred to medical examiner? | 11 2 1 | | | 26.Plac | e of Death (0 | Check only | one) | | | |
| of Vital Records, ng Physician: The law require the this certificate has been si meral director, page 2 should b | 2 | 1 ✓ Yes 2 No | Hospital: 1 / Inpatie | - | /Outpatient | | | Nursing Ho | | esidence 6 | Other: | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transitions. | | 27. Manner of Death 1 Natural 5 Dead | 28a. Date of Inju (Month Day Y Aug 9, 2006 | ry 28 | o. Time of In 100 hrs | | ury at Work? | ابروا | Describe ha | w injury occurre | ed | |
| ivisior or Attend after death Director: | ij | Feria | stigation | U | uknoc | UN | Yes 2 🗸 I | | | | | |
| Division tal or Attendir rs after death al Director: A | Certification: | | d not be 28e. Place of Inj | - | , farm, street | , factory, office | building, etc. | | or Town, Sta | te) | | Route Number, City |
| Divi | Š | 4 Homicide 29a. Certifuer 1 Certifuing Ph | mined (Specify) Stre | eet | | | | 433 | 3 4th Street | , Washington | , DC | |
| Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: | g | (Check only | nysician: To the best of my niner:On the basis of exar | | | | - | | | | | uuea/e) |
| To the within To the comp | Medical | 29b. Signature and title of certifie | and manner stated | andrand/c | | 29c. Licen: | | ou at tile | | | | |
| | 2 | 200, Signistare and title of certifie | Jano | 0 | | Į. | .M.E. | | | 29d. Date signe | | Day, 16df) |
| | | unge | THOUGH | 200 | | 0.0 | .171. 🗀 . | | | November | U, ZUUO | |
| 113/ | | 30. Name and address of person | who completed cause of distant Medical Exan | • | | treet, Baltim | ore MD | 21201 | | | | |
| 100 | | | 32 Registra | | 4 | LICCI, DAILIII | iole, MD | 21201 | | | | |
| St Regist | ate trar | 31 Date filed (Month, Day, Year) NOV 1 4 200 | 06 Karana | A. A | but | • | | | | | | |
| | _ | | | 7- | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU o For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Year Richard David Martin рм November 4. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 🛣 M 2 🗆 F Director Yrs. 069-40-5718 58 March 18, 1948 New York Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgamery Kensington 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? iled within 72 hours after death with 10422 Fawcett Street, Apt. 2 20895 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Amed Folces:
1 Yes 2 No
If Yes, Give
Year or Dates: 1969-70 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No SpecifyWhite Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dispatcher Delivery 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked oth any injury or other traumatic event SDES. 18. Mother's Name (First, Middle, Maiden Surname) Be David N. Martin Lillian T. Ebert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bret Martin/Son 748 Oakland Avenue, Oakland, California 94611 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November 10 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. aus 4 500 University Blvd, W. Silver Spring, MD 20901 23a. Part1. Enter the 3 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiopulnomary Arrest /Medical Due to (or as a consequence of): Examiner Arrhythmia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dira to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): ettending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Oid tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 20 No Be 25. Was case referred to medical 26. Place of Death |Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: tX Yes 2 No 1 Inpatient 2 X ER/Outpatient 3 DOA

٩ Certification:

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

this : After this funeral of I Director: / within 24 hours after To the Funerel Dire

State

Registrar

Medical

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Oescribe how injury occurred 1X Natural Injury 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Z Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) PO H0064588 11-4-06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashish Tolia, M.D.

1500 Forest Glen Road, Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

09 VON



| | | | 1 - For State Registrar | State of Maryla | | artment of I | | | ene | 3770 |
|----------------------------|--|-----------------|--|---|-------------------------------------|---|--|--|---|--|
| | Physic /Med | ical | Decedent's Name (First, Middle, L ELEANOI | R VIOLET M | ONAHAN | | | 2. Date of Death Month November | Day Year | 3. Time of Death |
| | Exami | B | 4a. Facility Name (If not institution, gi Frederick Memori 5. Social Security Number 6. | ial Hospital | s. last birthday) | 4b. City, Town, of Freder If Under 1 Year | | | 4c. County of Deat Frederi | ck |
| | Funera Director | | 215-38-5809 Usual Residence of Decedent | 1XM 2□F 92 | Yrs. | Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Y | 9. Birt Co | hplace (State or Foreig untry) Linois |
| | ith the Maryla or 28a-f shov | Director | 10a. State 10b. County Maryland Freder 10e. Street and Number | | ity, Town or Lo | ederick 10f. Zip Code | | 10g | . Citizen of What Co | 10d. Inside City Limits 1 ☐ Yes 2 No |
| 0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral | 7407 Willow 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced | 12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | l1 | 217 Vas Decedent of H Yes, specify Cuba | 02 dispanic Origin? (Sl an, Mexican, Puert Specify: | 1 | Jnited Sta 14. Race - Amer Black, White | ites rican Indian, |
| Maryland 21215-0036 | within 72 I piene. r than "nat the Medica | Completed | 15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) | ducation ade completed) College (1-4or 5+) 5+ | (Give I life. D | | eation during most of word d) | king 16 | b. Kind of Business/i | |
| vland | ould be filed Mental Hyg arked other | To Be C | 17. Father's Name (First, Middle, Last Hugh B. Wrighl | t) | _lH(| omemaker | | e (First, Middle, Mai | Own Horiden Surname) | me |
| e. Man | 1 and 2 sho Health and I I'm 27 is me | | 19a. informant's Name/Relationship (Pat Notestine | / Daughter | P.0 | D. Box 42 | and Number or Ru | ral Route Number, C | WV 25419 | |
| Baltimore. | permit. Pages 'Department of H Important: If Ite any Injury or ot | | 20a. Method of Disposition 1 Burial 20 Cremation 3 4 Donation 5 Other (Specifical Structure) | Removal from State | cemetery, crem | ition (Name of atory or other plac | e) 11/1 | 0/2006 F: | rederick, Funeral Ho | own, State Maryland |
| 68760, | Physician /Medical Examiner transit the private transit transit the private transit tr | edical Examiner | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a conseq c. Due to (or as a conseq d. | uence of): | 1621 Opo r the mode of dyin Le He | g, such as cardiac | Pika Fr | adomiol 1 | Approximate interval Between Onset and Death |
| P.O. Box | requires that the death certific een signed by the ettending p nould be detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown | Ideath 3 TE | ctopic pregnancy Other (specify) | | | 23d. Date of deliver | ery Day Year |
| | 1 | Completed by PI | Part II. Other significant conditions co | ontributing to death but not resu | ulting in the und | erlying cause give | n in Part I. | 23e. Did tobacc | co use contribute to the | he cause of death? |
| Division or Vital Records, | The la ate has page 2 | Be Compl | 25. Was case referred to medical | | | | 26 Place - f D - III | 24a. Was an autopsy performed 1 Yes 2 | death? | psy findings available mpletion of cause of 2 No |
| n or V | ng Physician: Iter this certificaneral director, I | ဍ | 27. Manner of Death | Hospital: 1 Inpatient 2 1 28a. Date of Injury (Month, Day Year) | 28b. Time of | 3 DOA Other | 4 LI Nuising Hor | | 6 □Other (Specifi | y) |
| Division | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Certification: | Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | | injury me, farm, street | M 1 □ Y | es 2□No | | and Number or Rura | l Route Number, |
| | he Hospi in 24 hour he Funer pletely fill | Medical | 29a. Certifier (Check only one) 1. ★ Certifying Phy 2 Medical Exam | /slcian: To the best of my know iner: On the basis of examinat and manner stated. | wledge, death o ion and/or inves | ccurred at the time stigation, in my opi | e, date and place, a nion, death occurre | and due to the cause ed at the time, date a | (s) and manner as st and place, and due to | ated. the cause(s) |
| | With Congression | | 29b. Signature and title of certifier | Porm | | 29c. License | number 8 6 | | Date signed (Month, I | Day, Year) |
| | Stat | е | 30. Name and address of person who concern the Austin Pearre, 31. Date filed (More Car Year) 3 20 | ompleted cause of death (Item M.D. 300 Wes | t 9th S | t., Fred | erick, MI | 21701 | | |
| | Registra | r | LAA IN C | A REFLICE | U Das | WILL | | | | |

| | | | 1 - For State Registrar | State of Ma | ryland / De <i>C</i> | partme <i>ertifica</i> | ent of H ate of L | ealth a Death | and M | | gierie | | 37708 |
|-------------|--|---------------------|---|---|--------------------------------------|----------------------------|-------------------------------|----------------------------|-----------------|---|--------------------|-----------------------------------|---------------------------------|
| | | | Decedent's Name (First, Middle, | Last) | | | | | | 2. Date of De. | ath | | 3. Time of Death |
| | Physici | | Harry Alexand | er McLeod | | | | | | Month 11 | 07 | 2006 | 3:25p M |
| | /Medic Examin | | 4a. Facility Name (If not institution, | | | 4b. Ci | ty, Town, or | Location of | of Death | • | | . County of Death | _ |
| | LAGITIII | | 3405 Purdue S | treet | | I | Iyatt | svil | le | | F | rince | George's |
| ī | Funeral | | 5. Social Security Number 6 | | (In yrs. last birthda | y) If Und | der 1 Year | If Under: | 24 Hrs. Min. | 8. Date of Birt | h V Year | 9. Birth | place (State or Foreign intry) |
| | Director | | 215-06-7415 | 1⊠M 2□F | 57 Yrs | Wichita | Days | Tiodis | IVIII I. | 8. Date of Bird (Month, Da 10/31/ | 49 | Jama | aica, W.I. |
| | pu . | | Usual Residence of Decedent 10a, State 10b, County | | 10c. City, Town or | Location | | | | | | | 10d. Inside City Limits |
| | anyla sho | <u>-</u> | | George | Hyatt | | le | | | | | | 1 PYes 2 □ No |
| | 788-f | ect | 10e. Street and Number | | | 104 | Zip Code | | | | 10a C | tizen of What Cou | inter? |
| | death with the Maryland ime 23s or 28s-f show r.must be notified at | 늅 | 3405 Purdue S | treet | | | 20783 | | | | - | ISA | and y: |
| | eath | eral | 11. Marital Status | 12. Was Decedent E | verin U.S. 1 | | | | nin? (Spe | ecify Yes or No | | 14. Race - Amer | ican Indian |
| 20 | be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "naturel", or Iteme 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral Director | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? 1 Yes 2 XN If Yes, Give | | If Yes, s | pecify Cuba 2 No | n, Mexican Specify: | , Puerto | Rican, etc.) | | Black, White Specify: B1 | , etc. |
| 2-0036 | hour | De De | 15. Decedent's | Year or Dates: | 16a De | cadant's II | sual Occupa | ation | | | 165 K | (ind of Business/li | ndustav |
| Ö | in 72 n n | Completed | (Specify only highest | grade completed) | (G | ve kind of DO NOT | work done of use retired | during mosi | t of worki | n <i>g</i> | 700. 1 | did of business/ii | idustry |
| 7 | iene. | Eo | Elementary/Secondary (0-12) 10th | College (1-4or 5- | L) | | inis | | | | Pri | vate | |
| 9 | Hygid other | BeC | 17. Father's Name (First, Middle, La | ist) | | | | 18. Mothe | er's Name | (First, Middle, | Maider | Surname) | |
| land | Aental Aental rked c | To B | Herbert McLec | d | | | | Mau | dly | n Codl | ing | 1 | |
| Mary | and Nema | | 19a. Informant's Name/Relationship | | | | | | | | | or Town, State, Zi | |
| Σ | end 2 selith n 27 i | | Patricia Elli | s-McLeod V | | | | ST. | | | lle | ,Md 20 | 783 |
| 9 | of He | | 20a. Method of Disposition 1 Burnal 2 □ Cremation 3 | □Removal from State | 20b. Place of Dicemetery, of Linstea | position (A | lame of r other plac | 9 | |)ate | 20c. L | ocation - City or T | own, State |
| Ě | Pag ment ant: | | 4 Donation 5 Other (Spe | | Linstea | | | - 1 | | 13 | | | • |
| Baltimore, | permit. Pages 1 end 2 should by Department of Heelth and Menta Importent: If Item 27 is marked any Injury or other traumatic e <u>ance</u> . | | 21. Signature of Funeral Service Li | censee | | 22. Name 409 | Fair | s of Facilit | s P | nead M l Ste | ort B M | uary Se litchell | ervice,P. <i>l</i> lville,Md |
| | | | 23a. Part1. Enter the disease, or or shock, or heart failure. List or | omplications that caused | the death. Do not | enter the m | ode of dyin | g, such as | cardiac c | or respiratory a | rrest, | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | 11111 | SCAN | 1FI | 2 | . 4 | | STA | | | Onset and Death |
| | /Medical | | resulting in death) | Due to (or as a | consequence of): | | / | 111 | |) / | 1 / 5 | | |
| | Examiner | | Surpostingly list conditions | b | | | | | | | | | |
| | D # | Iner | Saturation list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intend expects) | Due to (or as a | consequence of): | | | | | | | | |
| | ecute and trans | Examin | Cause (Disease or injury that initiated events resulting in death) Last | c. | | | | | | | | | |
| Ď, | cate be executed physicien end ; the burial-transit | Ē | , | Due to (or as a | consequence of): | | | | | | | | |
| 8/60 | physi the t | dicai | • | d. | | _ | | | | | | | |
| ם × | death certific a ettending p d for use es | Physician/Me | IF FEMALE: | 23c. If yes, outcome of | of pregnancy | | | | | | | 22d Date of deli- | |
| X Q Q | etten for u | lan | 23b. Was decedent pregnant in the past 12 months? | 1☐Live birth 2 4☐Pregnant at t | 2 Fetal death | 3 Ectopic | pregnancy | | | | | 23d. Date of deline Month | Day Year |
| j | the di y tha ached | ysic | 1 ☐ Yes 2 XNo 9 ☐ Unknown | 9 Unknown | and or dealin | o Line | зреспу) | | | | | | |
| <u>,</u> | thet the de led by tha e detached i | | Part II. Other significant condition | s contributing to death bu | t not resulting in th | underlying | g cause give | en in Part I. | | 23e. Did t | obacco | use contribute to | the cause of death? |
| S | 8 50 | d by | | | | | | | | 10 | Yes 2 | □No 3 Pro | babiy 4 [Unknown |
| Hecord | ~ D 70 | Completed | | | | | | | | 24a. Was | an | 24b. Were aut | opsy lindings available |
| e L | The law | m d | | · · · · · · · · · · · · · · · · · · · | | | | | | autor perfo | med? | prior to o | ompletion of cause of |
| Vital | | Ö | 25. Was case referred to medical | | | | | 26 Place | of Dooth | 1 Yes | 2 2 N | 1 ☐ Yes | 2∐ No |
| | | 0 0 | examiner? 1 ☐ Yes 252 No | Hospital: | nt 2 ER/Outpa | ient 3 | DOA Othe | 25 | rsing Ho | 1 | | 6 ☐Other (Spec | (fv) |
| 0 | | n: T | 27. Manner of Death | 28a. Date of Injur (Month, Day | y 28b. Tim | e of | 28c. Injury Work | | | 28d. Describe | | | ,, |
| ō | Attending I death. ctor: After y the funer | atio | 1 Accident 5 Pending 2 Accident investiga | | Year) Injui | M | | Yes 2 🗆 | No | | | | |
| DIVISION | r Atte | Certification: | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin | | ry - At home, farm, | street, fact | ory, office | | | 28f. Location (S | | | ral Route Number, |
| ב | Ital o | | | | | | | | | | | | |
| | To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the fune | Medical | 29a. Certifier 1 Certifying (Check only 2 Medical Exone) | Physicien: To the best of caminer: On the basis of and manner state | examination and/o | ath occurre investigati | ed at the tim on, in my op | ne, date an pinion, dea | d place, a | and due to the ed at the time, | cause(s date an | and manner as d place, and due | stated. to the cause(s) |
| | To the within 2 To the complete | Me | 29b. Signature and title of certifier | 1 | A | 7 2 | 29c. License | e number | | | 29d. Da | ate signed (Month | , Dey, Year) |
| | - > P O | | X Low | woh | 1/6 | and the second | Dn | 164 | 117 | 8 | Vai | rember. | 8 2001 |
| | 6 | | 30. Name and address of person w | no completed cause of de | ath (Item 23a) (Tvi | e, Print) | ンし | VO | | 0 | 100 | 2111000 | 1,5000 |
| | | | Harvinder Si | | | | NW St | te C- | -215 | 1 Wash | nino | gton.DC | 20010 |
| | Sta | ite | 31. Date filed (Month, Day, Year) | 32 Registra | r's Signature | 1 1 | , , , | | | | | | |
| | Regist | rar | NOV 0.9 | LUUD Man | . It A | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene = For Stata Registra Reg. No. 006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day NOV 6:02 P M WILLIAM H. MACKEY 6 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 12, 1 Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F Diréctor 460-34-7614 Yrs. 78 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f ehow 10d. Inside City Limits other traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2925 Beaverwood Lane death 20906 Funeral USA 12. Was Decedent Ever in U.S. Amed Forces?

1 XX Yes 2 □ No
If Yes, Give Year or Dates: Korea "naturel", or Iteme 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. e filed within 72 hours after dial Hygiene.
other than "naturel", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Lab Tech. Electrical Engineer Health Care Pages 1 and 2 should be filed vent of Health and Mental Hygicant: If Item 27 le marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Willie Aubrey Mackey Ora Mandine Pederson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health ar Important; if item 27 le any injury or other trau Helene Mackey / wife 2925 Beaverwood Lane, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory Nov. 11, 2006 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West, Silver Spring, MD 20901 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or com-shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MASSIVE BRAINSTEM ISCHEMIC STROKE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. physician Completed by Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9. Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2X No 3 Probably 4 Unknown should should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has page 2 s 2 XNo 1 Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📆 No 1 X Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: 3 ☐ Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOV 07 2006 941 0101240166 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 ERIK C. OSBORN MAJ MC USA 31. Date filed (Month, Day, Year) Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene () () (

| -3 | 7 | 7 | 1 | 0 |
|----|---|---|---|---|
| | | | | |

| | | | | | | Certifica | ate of | Death | | Reg. No. | 10 0 | 1110 | | | |
|---------------------|--|--|---|---|-------------------|------------------------------------|----------------------------|--|--|--|---------------------------------------|-------------------------|--|--|--|
| | Physicia | an | Decedent's Name (First, Middle, L. | | | | | | 2. Date of D Month | eath Day | Year 3. | Time of Death | | | |
| | /Medic | | Jose D. | | nez | | | | Nov. | 3,2006 | | 5:45a | | | |
| | Examin | er | 4e Facility Name (If not institution, ga | | th Co | | 4 | | r Location of Dea | th 4c. Count | y of Deeth | | | | |
| | | | Montgomery Vil | | | | 1224 11/222 | | rsburg | | tgomery | | | | |
| | Funeral Director | | 5. Social Security Number 214-70-4126 Usual Residence of Decedent | | (In yrs. last bir | Yrs. Month | der 1 Year S Days | If Under 24 Hi Hours Mi | n. (Month, D | rth a <i>y, Yeer)</i> 11 , 192(| (COUNTRY) | (Stete or Foreign | | | |
| | ye # | | 10a. State 10b. County 10c. City, Town or Location 10d. Insi | | | | | | | | | | | | |
| | Mary Figh | ğ | Md Montgo | mery | Mont | gomery | v Vil | lage | | | 1 | XYes 2□No | | | |
| | or 28 | <u>e</u> | 10e. Street end Number | | | 10f. 2 | Zip Code | | | 10g. Citizen of | Whet Country? | | | | |
| | th wit | ai D | 9913 Forest V | view Place | : | | 2088 | 6 | | Ţ | JSA | | | | |
| | r dea | net | 11. Marital Status | 12. Wes Decedent Ev Armed Forces? | er in U,S. | 13. Was Dec | edent of H | ispenic Origin? (| Specify Yes or Norto Rican, etc.) | 0- 14. Ra | ce - American Ind | dian, | | | |
| Maryland 21215-0020 | permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once. | Completed by Funeral Director | 1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: | | | | Specify: Salvado | | Specif | | :e | | | |
| 5 | "natu | ete | 15. Decedent's E (Specify only highest gi | ducation ede completed) | 16a. | Decedent's Us (Give kind of v | sual Occupa work done o | ation furing most of w | orki ng | 16b. Kind of B | b. Kind of Business/Industry | | | | |
| 12 | withir | E | Elementary/Secondary (0-12) | College (1-4or 5+ | | Minis | |) - | | Chur | cah | | | | |
| d 2 | Hygie ther ther | ပ္သ | 17. Father's Name (First, Middle, Las | 1) | | PILITA | CEI | 18 Mother's No | ame (First, Middle | | | | | | |
| an | d be set of c | To Be | Ignacio Uto | , | | | | | a Oreli | | 10) | | | | |
| ary. | shoul nd Ma meri imeti | - | 19a. Informant's Name/Relationship | (Type, Print) | 19b | . Mailing Addre | ss (Street a | | Rurel Route Numb | | State Zin Code | 90876 | | | |
| ž | nd 2 eith ai 27 is ir trac | | Saul Martinez/ | | | | | | nor Co | | | | | | |
| Baltimore, | eges 1 a ant of He t: if item y or othe | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci | 20c. Location - City or Town, State 06 Brentwood, Md | | | | | | | | | | | |
|)\frac{1}{2} | artme ortan injur | - | 21. Signature of Juneral Service Lice | 111 | 10.1 | 1 | | | | | | | | | |
| Ä | per Imp any | | > Xholo Ok | enles' | | 9241 | Colu | mbia B | I FUNE | lver Sp | | | | | |
| | | | 23a. Part1. Enter the disease, or conshock, or heart failure. List only | plications that caused the | ne death. Do r | not enter the mo | de of dying | g, such as cardia | ac or respiratory a | rrest, | Inten | oximate val Between | | | |
| 5 | Physician /Medical | | Immediate Cause (Final | | | | | | | | Onse | et and Death | | | |
| | Examiner | | disease or condition resulting in death) | a. Dem | entia | | | | | | ! | | | | |
| | | ē | | | | onsequence of | | lation | | | I I | | | | |
| | uted | Examiner | Sequentially list appelitions | b | | onsequence of | | Tacion | | | i | | | | |
| oʻ | certificate be executed uding physician end use as the buriel-transit | EX | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury | | 10 (01 a3 a 0 | | | | | | | | | | |
| 68760, | ate be nysici he bu | 0 | Cause (Disease or injury that initiated events resulting in death) Last | c. Du | e to (or as e c | onsequence of) |): | | | | | | | | |
| 9 × | ing ph e as t | Med Med | L | 4 | | | | | | | į | | | | |
| | | any | | d | | | | | | | | | | | |
| O | the a | Physician | Part II. Other significent conditions of | ontributing to death but | not resulting in | the underlying | cause give | n in Part I. | 23b. Did | tobecco use co | ntribute to the c | ause of deeth? | | | |
| P.0 | es that the deeth cer igned by the attendin be deteched for use | | | | | | | | 1 🗆 | Yes 28 No | 3 Probably | 4 Unknown | | | |
| Records, | requires that the deeth een signed by the atter hould be deteched for i | o b | | | | | | | 240 11100 | | 24b. Were aut | topou findings | | | |
| 00 | v require been si should t | Completed | | | | | | | | an autopsy med? | available completion | prior to on of cause | | | |
| Re | e lav hes ge 2 | Ē | | | | | | | | _ | of death? | | | | |
| = | ician: The certificate rector, pag | | 25. Was case referred to medical | | | | | | | res 2⊠No | 1 ☐ Yes | 2 No | | | |
| > | | o ne | examiner? | Hospital: 1 ☐ Inpatient | 2 ER/Out | patient 3□ D | Othe | | ath (Check only only only only only only only only | | · · · · · · · · · · · · · · · · · · · | | | | |
| | g Phys arthis eral di | | 27. Manner of Death | | | | 28c. Injury | et Nursing I | | now injury occurr | | | | | |
| 0 | Attending in death. | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 4 Homicide 6 Could not be determined 1. Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury et Work? 1 Yes 2 No 28d. Descrive Work? 1 Yes 2 No 28d. Descrive Work? 28d. Descrive Work? 28d. Descrive Work? 28d. Descrive Work? 28d. Descrive Work? 28d. Descrive Work? 28d. Descrive Work? 28d. Descrive Work? 28d. Descrive Work? 28d. Descrive Work? 28d. Descrive Work? 28d. Descrive Work? 28d. Descrive Work? 28d. Descrive Work? 28d. Descrive Work? 28d. Descrive Work? | | | | | | | | | | | | | |
| | Atten er deal ector: by the | | 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined | 28e. Place of Injury building, etc. (| - At home, fan | m, street, factor | ry, office | | 28f. Location (S City or Tox | Street and Numb | er or Rural Route | e Number, | | | |
| ۵ | tal or rs afte al Dir led in | Se | | building, etc. (| <i>эрвспу)</i> | | | | Only of 100 | ni, State) | | | | | |
| | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director. | egical | 29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam | ysician: To the best of n niner: On the basis of ex | amination and | death occurred or investigation | at the time | e, date and place inion, death occu | e, and due to the urred et the time, | cause(s) and ma date and place, a | nner as stated. and due to the ca | ause(s) | | | |
| | To the within 2 To the comple | - | 29b. Signature and title of certifier | and manner stated | 1 | | c. License | | | | d (Month, Dey, Y | | | | |
| | F 3 F 8 | | | \ X | λ | | D005 | | | Nov. 9, | | , | | | |
| • | ı | - | 30. Name and address of serson who | completed cause of deet | h (Item 23a) /7 | [vne Print] | | | | , | | | | | |
| | | 1 | Anushiravan D | | | | ical | Conto | r Dr. R | ockill | C PM O | 0.850 | | | |
| | State | 3 | 31. Date filed (Month, Day, Year) | 39. Registrar's | Signature | Lades | | CCITCE | L DI. K | CONTIL | c, Mu Z | 0000 | | | |
| | Registra | | NOV 1 3 20 | Uh Bea | 15. 4 | BPS AGA | | | | | | | | | |

| _ | | 1 - For State Registrar | | | | nd / Depa | | of H | ealth and | Mental Hy | | nns | 37 | 711 |
|--|--|---|---|---|---|--|---|-------------------|--------------------------------------|---------------------------------------|---------------------------|---|----------------------------------|-----------------------|
| | Physician /Medical | Poboo | me <i>(First, Middl</i> e, La ca Mach | • | | | | | | 2. Date of D Month Novemb | Day | | 3. Time 9:1 | of Death |
| | Examiner | | (If not institution, gi | ve street and nur | mber) | | 4b. City, T | own, or | Location of Dea | | | County of Dea | | |
| | | Hebrew 5. Social Security | | Sex | 7 Ann //n wm | la at hirth days | Rock | | e If Under 24 Hrs | | | lontgome | | |
| | Funeral Director | 098-10-9 | 9440 | 1 M 2 | 7. Age (In yrs. 90 | Yrs. | | Days | Hours Min. | | rth Pay Year) -1916 | 9. Bin Co P o | hplace (State puntry) land | or Foreign |
| | Maryland f ahow led at | 10a. State | 10b. County | | | ty, Town or Lo | | | | | | | 10d. Inside (| City Limits |
| | or 28e- | 10e. Street and N | Montgor | lery | KOC | kville | 10f. Zip (| Code | | | 10g. Citi | izen of What Co | | |
| | 23a (23a Caral Dark | 6121 Mor | trose Rd | | | | 208 | 852 | | | | U.S.A. | | |
| 36 | be filed within 72 hours after death with the Maryland hat Hygiene. Ind other than "natural", or Itama 23a or 28e-f ahow avent, the Medical Examiner must be neutified at Be Completed by Funeral Director | 11. Marital Status 1 □ Never Ma | rried 2 Married | 12. Was Dece Armed Fo 1 Tes If Yes, Gin Year or D | 2 <u>™</u> No ⁄e | | Was Decede If Yes, specif 1 ☐ Yes 2 | | | Specify Yes or N to Rican, etc.) | | 14. Race - Ame Black, Whit Specify: | e, etc. | |
| 5-00 | 72 hours nature | (Spe | 15. Decedent's E | ducation | | 16a. Dece | dent's Usual | Occupa: | tion uring most of wo | rking | 16b. Ki | nd of Business | hite Industry | |
| 121 | ed within 72 houygiene. Per than "natura" t, the Medical Completed | Elementary/Sec | | College (1 | -4or 5+) | | wner/ | | | ixing | G | rocerv | | |
| Maryland 21215-0036 | should be filed within nd Mental Hygiene. marked other than wratic avant, the Martin avant of the Martin avant of the Compile of the Martin avant of the Compile of the Martin avant of the Compile of the Martin avant of the Compile of the Martin avant of the Martin a | 17. Father's Name | e (First, Middle, Las abinowitz | ·) | | | , wilding | | 18. Mother's Na | me (First, Middle Yaberosl | e, Maiden | | | |
| Mary | 2 6 2 6 | 19a. Informant's I | Name/Relationship Heyman-dar | *, . | | 19b. Mailir 14 Do | ng Address (| Street at | nd Number or Re | ural Route Numt | per, City o | r Town, State, 2 | Zip Code) 20886 | |
| Baltimore, | 90 = 5 | | sposition Cremation 3 [5] Other (Speci | | State (| Place of Dispo cemetery, crem | natory or oth | e of ner place | · | Date 9-06 | | cation - City or | | |
| Ba∰ & | permit. Pag Department Important: any injury once. | | uneral Service Lice | - | T P | 22 | Danara | | of Gor Indbe | rg Memo e Rockv | rial | Chapels | s, Inc. | |
| _ | THE STATE OF THE S | | the disease, or contant failure. List only | plications that cone cause on e | aused the deat ach line. | | | | | | | , IID 200 | Approxima Interval Be | tween |
| | Physician /Medical | Immediate Cause disease or condit resulting in death | ion | w | ume or as a conseq | | letio | n | | | - | | 5 day | |
| 60, | siclen and instantinansit an Examiner | fany, leading to cause. Enter Und Cause (Disease of that initiated even resulting in death) | on ditions, immediate deetying or injury ts) Last | c. Cer | o as a consequence or as a consequence | juence of): /ascu | lar | dis | ease | | | | one u | eas ears |
| Division of Vital Records, P.O. Box 68760, | Physician: The law requires thet the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the buriat-transit. To Be Completed by Physician/Medical Examir | IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow | 2 months? | | inth 2 ☐ Feta ant at time of d | Ideath 3 | Ectopic pred | | | | 2 | 23d. Date of deli Month | - | Year |
| rds, F | w requires the been signed should be de | Part II. Other sign | ificant conditions | contributing to de | ath but not res | ulting in the ur | nderlying cau | use giver | in Part I. | | | se contribute to ZNo 3 □ Pro | | |
| al Reco | : The law requi | | | | | | | | | 24a. Was auto perfo 1 Yes | psy ormed2 | 24b. Were au prior to death? | topsy findings ompletion of | available cause of |
| V:ta | sician certifi rector | 25. Was case refe examiner? | / | Hospital: | | - | | 7 | | ath Check only | | | | |
| on of | Sing After fune | 1 ☐ Yes 2 ☐ 27. Manner of Dea 1 ☑ Natural 2 ☐ Accident | 5 140 | 28a. Date of | npatient 2 of Injury h, Day Year) | ER/Outpatien 28b. Time of Injury | | c. Injury a | 4 (wirsing H | lome 5 Resi 28d. Describe | | | aty) | |
| Divisi | tal or Attending Presents after death. el Director: After led in by the funera | 3 Suicide 4 Homicide | 6 Could not b | e 28e. Place | of Injury - At hong, etc. (Specif | ome, farm, stre | | | | 28f. Location (City or To | Street and wn, State) | d Number or Ru | ral Route Num | nber, |
| | To the Hospital or Attent within 24 hours efter death To the Funerel Director: completely filled in by the Medical Certificat | 29a. Certifier (Check only one) | 1 Certifying Pr 2 Medical Exa | nysician: To the miner: On the ba and mann | SIS OF GRAFIIIII | wledge, death tion and/or inv | occurred at restigation, in | the time | , date and place nion, death occu | , and due to the tred at the time, | cause(s) a | and manner as place, and due | stated. to the cause(| s) |
| | To th within To th compl | 29b. Signardre and | d title of certifier | 1/2 | 10 1 | | | License | | | | signed (Month | | |
| | 1 | 30. Name and add | dress of pers n who | completed cause | of death (Item | n 23a) (Type, I | Print) | 103 | 146 | t 1 e, mD | Nove | ember | 7,200 | 6 |
| | CALL | 31. Date filed (Mo. | . Kuhn, 1 | nD 4 | 221 M egistrar's Signa | iontros | e Roc | d 1 | Rockville | e, mo | 20 | 0852 | | |
| 3. | State Registrar | 5 54to 1160 (140) | | 2006 | Bus A | 1 1 | will! | | | | | | | |

State of Maryland / Department of Health and Mental Hygien 2006 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 2, 2006 8:00 A.M **Physician** Doris Cleaveland Morrow /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Country Living Poolesville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Sept. 28, 1919 9. Birthplace (State or Foreign Country) Illinois 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 87 Months 1 ☐ M 2 🖫 F 578-22-0364 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydene. Important: If Item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury of other traumatic event, the Madical Examiner must be notified at once. Poolesville Montgomery Maryland 1 ☐ Yes 2 ☐ No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15201 Montvideo Road United States 20837 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Š 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lenore Darine Head Henry William Cleaveland 19h, Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 17243 Spaces H111 Road 19a. Informant's Name/Relationship (Type, Print) William Morrow/ Son Poolesville, MD 20837 20b. Place of Disposition (Name of 20a. Method of Disposition Date 2 20c. Location - City or Town, State George town of the less ity Medical Center Nov. 2006 Washington, D.C. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Columbia Mortuary Services, P.O. Box 58007 Washington, D.C. 20037 Inc. estan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SC Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (bisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner?
1 X Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Natural Injury 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun М 1 Tes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapper stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ro ome DO0428

State

31. Date filed (Month, Day, Year) 2006 NOV 13 Registrar

BRECKER mo omE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 (0) / M & L C J

| | | - | For State | State o | f Maryland | | artment o | | | | - | 2000 | 37713 |
|----------------|---|---------------------|--|--|---|---|--|---------------------------------|---------------------|-------------------------------------|---|-------------------------------|---|
| | | | 1 Decedent's Name (First Middle Last) 2. Date of Death | | | | | | | | | | 3. Time of Death |
| ı | Physici /Medic | | Mary Catheri | | Month Novemb | Day | 2006 | 2:20 A. M | | | | | |
| | Examin | | 4a. Facility Name (If not institution | , give street and nu | 4b. City, Tow | _ | | | 4c. County of Death | | | | |
| | | | Sligo Creek Nur | sing & Re | hab. Cen | | | | koma Park | | | Montgom | |
| | Funeral Director | | 5. Social Security Number 218–20–0795 | Months Da | | Hours Min. 8. Date of 1 (Month, 6/12/ | | | | thplace (State or Foreign buntry) | | | |
| | D > | | Usual Residence of Decedent 10a. State 10b. County | | 10c City | Town or L | neation | | | | | | 10d. Inside City Limits |
| | Aaryla f ehov | ō | | George's | | Bren | | | | | | | 1.□Yes 2□No |
| | r 28a- | rect | 10e. Street and Number | e George s | 5 IV. | brein | 10f. Zip Coo | ie | | | 10g. Cit | izen of What Co | ountry? |
| | th with | ai D | 3910 Allison S | treet | | | | 20 | 722 | | | U.S.A. | |
| 936 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f ehow important: If item 27 is marked other then "natural", or items 23a or 28a-f ehow appring yor other traumatic event, the Medical Examinant to another appress. | by Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☒ Widowed 4 ☐ Divorced | Armed Fo | ve X No | . 13. | Was Decedent If Yes, specify (1 ☐ Yes 2/2 | Cuban, Mexic | can, Puerto F | cify Yes or No Rican, etc.) | 0- | | |
| 2-0 | 72 ho | eted | 15. Decedent (Specify onfy highes | | | (Give | edent's Usual Oc kind of work do | one during m | ost of workin | g | 16b. K | ind of Business | /Industry |
| 21215-0036 | d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other then "r traumatic event, the Med | Completed | Elementary/Secondary (0-12) 9th | College (| | life. | DO NOT use re lerk | atired) | | | | Bank | |
| | other | Be C | 17. Father's Name (First, Middle, | Last) | | | | 18. Mo | ther's Name | (First, Middle | , Maiden | | |
| ylar | Menta Menta arked | ToE | Howard Skelt | | | | | | | inia H | | | |
| Maryland | d 2 shoth and the and the most traum | | 19a. Informant's Name/Relations Jean Baker/ Dau | | | | | | | | | or Town, State, . 1. 20781 | Zip Code) |
| | is 1 and of Health item 27 othar tr | | 20a. Method of Disposition | - | l cer | ice of Disp | osition (Name o | f place) | D | ate | 20c. Lo | ocation - City or | Town, State |
| Ē | Pages ment of ant: If it ury or o | | 1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S | | 1 | | coln Cen | | 11/15 | | | | Maryland |
| Baltimore, | permit. Departr Imports eny inju | | 21. Signature of Funeral Service | | natt | 2 | 2. Name and Ad H.S. Wa 1925 Bu | dress of Fa errough | ton & s Ave. | Sons C | o.,I Wash | nc. nington, | D.C. 20019 |
| | | | 23a. Part1. Enter the disease, or shock, or heart failure. List | complications that only one cause on | caused the death. each line. | Do not er | ter the mode of | dying, such | as cardiac o | respiratory a | arrest, | | Approximate Interval Between Onset and Death |
| | hysician /Medical | | Immediate Cause (Final disease or condition resulting in death) a. Myocardiopathy Due to (or as a consequence of): | | | | | | | | | | |
| 1 | Examiner | | | | or as a conseque onic Obst | | ive Lunc | n Disa | 250 | | | | Years |
| | 7 = | ner | f any, leading to immediate cause. Enter Underlying | | (or as a conseque | | eve hang | 1 DISC | abc | | | | rears |
| | ecuted and -transi | Examin | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to | onia Rena (or as a conseque | 1 Fa | lure | | | | | | Years |
| 8760, | cate be executed physicien and the burial-transit | dical E | , | d | (or as a conseque | 311CG G1). | | | | | | | |
| 9 | rtificat ng phy s as th | 0 | IF FEMALE: | | | | | _ | | | | | |
| P.O. Box | it the death certific by the attending p tached for use as | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 Live | atcome of pregnan- birth 2 ☐ Fetal of nant at time of dea nown | death 3 | □Ectopic pregn □ Other (specif | | | 13 | | 23d. Date of de Month | livery Day Year |
| rds, P | w requires that the been signed by th should be detache | ed by PI | Part II. Other significant condition Osteoporosis | - | death but not resul | ting in the | underlying caus | e given in Pa | urt I. | 23e. Did | o the cause of death? robably 4 Unknown | | |
| Vital Records, | e law has b | Completed by | Anaemia | | | | | | | 24a. Was auto perf 1 ☐ Yes | omed? | prior to death? | utopsy findings available completion of cause of s 2 No |
| /ita | | Be | 25. Was case referred to medica examiner? | | | | | | | (Check only | | | |
| 6 | Physical distribution | 2 | 1 Yes 2 No 27. Manner of Death | | | R/Outpatie | of 28c | Injury at | | ne 5 Res | | 6 ☐Other (Spe | ecify) |
| O | Jing After fune | tion | 1 ⊠Natural 5 ☐ Pendir 2 ☐ Accident investi | | of Injury oth, Day Year) | Injury | м | Injury at Work? 1 ☐ Yes 2 | | | | , | |
| Division of | Hospital or Attence A hours after death Funeral Director: etely filled in by the | Certification; | 3 Suicide 6 Could 4 Homicide determ | inad 289. Plac | e of Injury - At hon ding, etc. (Specify) | me, farm, s | treet, factory, of | fice | 2 | 28f. Location City or To | | | lural Route Number, |
| | lospital or hours afte uneral Dir siy filled in | | 00- 0 | - Bhusiaise T- th | - hast of my trans | dedee de | | | | and due to the | |) and manner o | a stated |
| | To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by t | Medical | | ng Physician: To the Examiner: On the and ma | | | | | | | | | |
| | To the within 2 To the comple | Me | 29b. Signature and title of certifie | · D. | 7 0 | | | cense numb | | | | ate signed (Mon | |
| | | | Kama | h/i | I will | <u>(' </u> | | 019609 | | | IVC | v. 10,2 | .006 |
| 2 | | | 30. Name and address of person Raman R. T | | | | | Mt - F | Rainia | ar Ma | arv1 | and 2 | 20712 |
| 4 | St | ate | 31. Date filed (Month, Day, Year) | 20 | Desistrado Cianot | | | | | | <u>1</u> - | | · · · • |
| | Regist | rar | NOV 1 3 20 | Ub Bare | Hegistrar's Signatu | open | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** November 07,0 EMMA LISSY MAHONEY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 34/13/14/4 Nicomico If Under 1 Year If Under 24 8. Date of Birth (Month, Day, Year) APRIL 23,1923 Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days Hours 1 □ M 2 X F 216-40-4936 83 GERMANY Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 No Director MARYLAND WICOMICO PARSONSBURG 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7585 JONES HASTINGS ROAD 21849 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗖 No Baltimore, Maryland 21215-0036 Specify WHITE Specify. 2 3 XWidowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER OWN HOME permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 is marked other 1 any Injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN UNKNOWN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PETER L. MAHONEY/SON O. BOX 123, PARSONSBURG, MARYLAND 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State WICOMICO MEMORIAL PK. 11/13/2006 SALISBURY, MARYLAND 5 Other (Specify) 4 □ Donation 21. Signature of Funeral Service Lice see ZELLER FUNERAL HOME, P. O. BOX 3171 1212 OLD OCEAN CITY ROAD, SALISBURY, Approximate Interval Between Onset and Death ada. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): days **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year 1 Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 hol To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

29b. Signature and title of certifie

STEPHAN

ИL

31. Date filed (Month, Day, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAVLOS

mo

mo

400 E. SHORE DR

29c. License number

D41721

SALISBURY

29d. Date signed (Month, Day, Year)

07/06

21804

| | | | For State Registrar | State of | f Marylan | | artmen rtificate | | | | | giene Reg. No. | 2006 | 377 | 715 |
|-------------------------------------|---|-----------------|--|--------------------------------------|-------------------------------------|--------------------------------|---|--------------------|-------------------|------------|--|--|---------------------------------|------------------------------|-----------|
| | | | 1. Decedent's Name (First, Middle, | Last) | - | | | | | | 2. Date of De Month | ath Day | Year | 3. Time of I | Death |
| | Physici /Medic | | Wallace Spedde | n Mooney | | | | | | | Novembe | er 6 | 2006 | 2225 | М |
| | Examin | er | 4a. Facility Name (If not institution, | give street and num | nber) | | 4b. City, | Town, or | Location | of Death | | | County of Death | | |
| | | | Hospice At The | | | | | isbu | | O.A. Uso | | | licomico | | |
| | Funeral | | 5. Social Security Number 218-14-4421 | 6. Sex 14 M 2 ☐ F | 7. Age (In yrs. i | iast birthday) Yrs. | If Under Months | Days | If Under Hours | Min. | 8. Date of Bir (Month, Da Dec 11 | th i <i>y, Year)</i> 10 າ | 9. Birth Coa 4 Mary | place (State or intry) | ' Foreign |
| | Director | | Usual Residence of Decedent | | 81 | | | | | | Dec. 11 | ,172 | 4 Flat y | Tanu | |
| 1 | ow ow | | 10a. State 10b. County | | 10c. City | y, Town or Lo | ocation | | | | | | | 10d. Inside City | y Limits |
| 5 | Man F | ţ | Maryland Dorches | ter | | Secret | arv | | | | | | | 1 📉 Yes | 2 🗆 No |
| J | r 28s | Irec | 10e. Street and Number | | - | | 10f. Zip | Code | | | | 10g. Citi | zen of What Cou | intry? | |
| 00 | h wit | Funeral Directo | 107 Academy Str | eet | | | | 216 | 564 | | | | USA | | |
| do | deal | ner | 11. Marital Status | Armed For | dent Ever in U. | S. 13. | Was Deced | ent of Hi | spanic Ori | igin? (Spe | ecify Yes or No Rican, etc.) |)- | 14. Race - Amer Black, White | | |
| 9 | or It | E | 1 Never Married 2 Marrie | d 1 X Yes | 2 No 1 74 | 3 | 1 ☐ Yes 2 | | | | | | Specify: Wh | | |
| 8 | ural', | d by | 3 Widowed 4 Divorced | If Yes, Give Year or Da | ates: 194 | 0 | | | | | | | | | |
| 5 | "nat | Completed | 15. Decedent' (Specify only highest | | | (Give | dent's Usua kind of wor DO NOT us | k done d | during mos | t of work | ing | 16b. Kii | nd of Business/l | ndustry | |
| 7 | withir ane then | μ̈ | Elementary/Secondary (0-12) | College (1 | -4or 5+) | | ng De | | • | rvie | ar. | Garm | ent Manı | ıfactur | ino |
| D 0 | Hygie ther ther | ပို | 17. Father's Name (First, Middle, L | ast) | | Outer | 116 00 | PC. | | | First, Middle | | | ITACCAI | <u> </u> |
| an | d be ental | To Be | William Richard | d Mooney. | Sr. | | | | G | ladv: | s Sue S | aund | ere | | |
| <u>_</u> | shoul nd Ma mari | ۲ | 19a. Informant's Name/Relationsh | | 52. | 19b. Mailir | ng Address | (Street 2 | | | | | Town, State, Z | p Code) | |
| × | nd 2 uith au | | Isabelle Mooney | /Wife | | P. 0 | Box | 93. | Sec | reta | rv. Mar | v1an | d 21664 | | |
| ā, | f Hee f Hee item othe | 1 | 20a. Method of Disposition | | 20b. P | lace of Dispo emetery, crer | | | | | Date | | cation - City or T | own, State | |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Iteme 23s or 28s-f ehow eny injury or other traumatic event, the Medical Examiner must be notified at once. | | 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp | | Jiai o | | | | 1 | 11/14 | 12006 | Beu | lah, Mai | vland | |
| <u>=</u> | mit. Dorta V inju | | 21. Signature of Furieral Service | | 11 | | | | | | P. O. | | | 2 2 2 2 2 2 | |
| m | 20 E 9 | | Konand | 10 X | ller | 10 | 6 Mai | n St | reet | , Eas | st New | вох Mark | et, MD 2 | 21631 | |
| | | | 234. Part. Enter the disease, or shock, or heart failure. List | complications that can | aused the death | n. Do not ent | ter the mode | of dyin | g, such as | cardiac o | or respiratory a | rrest, | | Approximate Interval Belw | ween |
| | Physician | | Immediate Cause (Final disease or condition | n. | restu | H | | A | Fran | lun | , | | | Onset and D | eath |
| | /Medical | | resulting in death) | a | er as a consequ | uence of): | | | 1 | 7000 | · | | | | |
| | Examiner | | Conventially liet conditions | h | | | | | | | | | | | |
| | <u>ت</u> و | ner | Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (| or as a consequ | uence of: | | | | | | | | | |
| | Attending Physicien: The law requires that the death certificate be executed ar death. •ctor: After this certificete has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c | | 0 | | | | | | | | | |
| 8760, | cien a | Ē | rooding in dourn Edot | Due to (| or as a consequ | uence or); | | | | | | | | | |
| 87 | physi s the t | dical | | d | | | | | | | | | | - | |
| 9 × | eath certific ettending pl for use as t | Physician/Me | IF FEMALE: | 23c. If yes, outo | come of pregna | nev | | | | | | | 104 D-1- 44 4-15 | | |
| Bo | etten for u | lan | 23b. Was decedent pregnant in the past 12 months? | 1 ☐Live bi | irth 2 ☐ Fetal ant at time of de | Ideath 3□ | Ectopic pro | | | | | - | 3d. Date of deliving Month | , | /ear |
| oʻ | the d | ysic | 1 □ Yes 2 □ No 9 □ Unknown | 9□ Unkno | | 50 | J 01.101 (4px | July | | | | | | | |
| σ. | res that the de igned by the e be detached t | | Part II. Other significant condition | s contributing to de | ath but not resu | ulting in the u | nderlying ca | ause give | en in Part I | | 23e. Did t | obacco u | se contribute to | the cause of de | eath? |
| sp. | uires I Sigr | d by | | | | | _ | | | | 1 🗆 ' | Yes 2 | ZNo 3□Pro | bably 4 🗆 U | Jnknown |
| ō | w require been si should t | Completed | | | | | | | | | 24a. Was | an | 24b. Were aut | opsy findings a | available |
| Re | he lav e has age 2 | Ë | | | | | | | | | | rmed? | prior to co | ompletion of ca | ause of |
| tal | en: T | Be C | 25. Was case referred to medical | | | | | | 26 Place | of Death | 1 ☐ Yes | 2/21No | 1 🗆 Yes | 2 No | |
| 5 | ysicie s cer direct | To B | examiner? 1 ☐ Yes 2 ☑ No | Hospital: | npalient 2 🗆 | ER/Outpatier | nt 3 DO | A Othe | 200 | | | | G □Other (Spec | ifv) | |
| 9 | g Ph er th eral | | 27. Manner of Death | 28a. Date o | of Injury h, Day Year) | 28b. Time of | | Bc. Injury Work | | - | 28d. Describe i | | | .,, | |
| <u></u> | death. ctor: Aft y the fur | atio | 1 Natural 5 Pending 2 Accident investig | | n, Day reary | плиту | М | | Yes 2□ | No | | | | | |
| Division of Vital Records, P.O. Box | r Atte er de recto by th | Certification; | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine | 288. Place | of Injury · AI ho | ome, farm, str | reet, factory | , office | | | 28f. Location (: City or Tox | Street and | d Number or Rui | al Route Numb | ber, |
| Ō | tal or A | Çe | | | | | | | | | | | | | |
| | To the Hoepital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificete ha completely filled in by the funeral director, page | edical | 29a. Certifier Certifying | Physician: To the xaminer: On the ba | best of my kno | wledge, death | h occurred a | at the tim | ne, date an | nd place, | and due to the | cause(s) | and manner as | stated. |) |
| | the H the F the F | Medi | one) | and mann | er stated. | | | | | | | | | | |
| • | or or or no | 2 | 29b Signature and title of ceptifier | 001 | / 110 | 1 | 290 | . License | number | | | 29d. Date | signed (Month | Day, Year) | |
| | | | | | Inv | <i>b</i> | | 0 | 716 | 1/ | 8 | [1 | -/- | 06 | |
| | | | 30 Name and address of person v | no completed cause | e of death (Item | 23a) (Type, | Print) | 11 | | AA | 1 17 | 77 ' | 2/1 | Mr a. | 607 |
| | CA | • 0 | 31. Date filed (Month, Day Year) | 32. Re | egi frar's Signa | ture | 105/4/ | 1105 | pre | 100 | 17 021/7 |) (| Jec115h | MULL | 001 |
| | Sta | re Or | NOV | 3 2006 L | Man . | K | Anne | 61 | | | | | | ` | |

| | | 1 | For State Registrar | State of M | Maryland | d / Depa <i>Cei</i> | artmen rtificate | t of H | lealth a | and M | | Reg. N | 2006 | 37716 | |
|--|---|---------------------|---|---|--------------------------|--|---|------------------|----------------------------|-------------------------|--|----------------------|---------------------------------------|--|--|
| | Physicia | | Decedent's Name (First, Middle, La | | | | | | | | 2. Date of D | | 2006 Year | 3. Time of Death | |
| | /Medic | al | Marian R. Mos | | 24) | | 4h Cihi | Tours or | Location of | of Dooth | Nov. | - | 2006 4c. County of Dea | 11:45 a M | |
| | Examin | er | 4a. Facility Name (If not institution, giv Talbot Hospice | | 91) | | | asto | | or Death | | | - | albot | |
| | Funeral | | 5. Social Security Number 6. S | Sex 7. | Age (In yrs. la | ast birthday) | If Under Months | | If Under Hours | 24 Hrs. Min. | 8. Date of B. | irth | 9. Bir | thplace (State or Foreign buntry) W York | |
| | Director | - | 0/3-01-2956 | □ M 2 F | 90 | Yrs. | Moritais | Days | Tiodis | Nether. | April | 16, | 1916 Ne | w York | |
| and | 1 | } | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Lo | cation | | | | | | | 10d. Inside City Limits | |
| Mary | works 1-1 | to | Maryland Talbo | t | | | Ea | sto | n | | | | | 1 √es 2 □ No | |
| F . | or 28s e roll | Oirec | 10e. Street and Number | | | | | | | | | | g. Citizen of What Country? | | |
| d 21215-0036 filed with the Maryland | 8 23a | by Funeral Director | Apt. 311, 640 Mec | | | 2 42.5 | Man Dana | | 21601 | i=i=2 /C= | aifu Van ar N | | 14. Race - Ame | USA | |
| 7 ja ja ja ja ja ja ja ja ja ja ja ja ja | Hem | nne | 11. Marital Status1 ☐ Never Married2 ☐ Married | 12. Was Decede Armed Force 1 Tyes 2 | s? 🔎 | | | | | | cify Yes or N Rican, etc.) | 10- | Black, Whi | | |
| 036 | Exam | by | 3 | If Yes, Give Year or Date | | | 1 ☐ Yes | 2□No | Specify: | | | | Specify: W | nite | |
| 5-0 | fical | Completed | 15. Decedent's E (Specify only highest gra | ducation ade completed) | | 16a. Dece (Give | dent's Usua kind of wor DO NOT us | l Occup | ation during mos | t of worki | ng | 16b. | Kind of Business | /Industry | |
| 121 Mithin | than the Me | idm | Elementary/Secondary (0-12) | College (1-4c | or 5+) | | Offic | | | | | To | ournalism | | |
| 4 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | Hygie othar snt, | Be Co | 17. Father's Name (First, Middle, Last |) | | | OLLIC | LE W | | er's Name | (First, Middle | | | II. | |
| rland | Aental rkad tic sv | To B | William Rusk | | | | | | Jo | seph | ine Wh | ite | | | |
| Maryland 21215-0036 | and N is me sume | | 19a. Informant's Name/Relationship (| | | | | | | | | | y or Town, State, | Zip Code) | |
| 6, 7 | tealth nm 27 thar tr | | Nancy M. Howie/Da | lugnter | 20b Pt | Maria and a second | | | | | Caston, Date | | 21601 Location - City or | Town, State | |
| nor ages | nt of h t: Wita /orol | | 1 Burial 2 Cremation 3 | | nte Mid | lace of Dispo emetery, crer Shore(| natory or o | ther place | ente | | | | | Maryland | |
| Baltimore, | Department of Health and Mental Hygiene. Important: If itam 27 is markad other than 'natural', or items 23s or 28s-1 shov any injury or other traumetic svsnt, it is Medical Evand actinust be rotified at once. | | 4 □ Donation 5 □ Other (Special21. Signal re of Funeral Sorvice Lice | _ | JI III C | | | - | | | The second secon | - | P.O. Box | | |
| m m | Depa Impo any ir | | failles ture | ac-120 | mie | | | | | | ambrid | | | | |
| | | | 23a. Perri. Enter the disease, or com shock, or heart failure. List only | one cause on each | sed the death h line. | . Do not ent | er the mod | e of dyin | ig, such as | cardiac o | or respiratory | arrest, | | Approximate Interval Between Onset and Death | |
| | ysician | | Immediate Cause (Final disease or condition resulting in death) | a. (0 | lan | Ca. | nce | 7 | | | | | | 5 MONTH | |
| | Medical caminer | | | Due to (or | as a consequ | ience of): | | | | | | | | | |
| | | Jer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hijury that initiated events | b. Due to (or | as a consequ | ience of): | | | | | | | | | |
| cuted | hysician and the burial-transit | Examiner | Cause (Disease of injury that initiated events | c | | | | | | | | | | | |
| 7 60, te be execu | cian a purial- | E EX | resulting in death) Last | Due to (or | as a consequ | ience of): | | | | | | | | | |
| 387 Icate t | physics the b | dicai | | d | | | - | | | | | | | | |
| /ision of Vital Records, P.O. Box 68 | attending p for use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcor | me of pregna | | 75-4 | | | | | | 23d. Date of de | livery | |
| Geath | the atte | sicia | in the past 12 months? 1 ☐ Yes 2 ☐ No | | t at time of de | | ∃Ectopic pr ∃ Other (sp | | | | | | Month | Day Year | |
| P.O. | igned by the be detached | Phy | 9 ☐ Unknown | | | ulting in the u | nderhina c | alice div | en in Part I | | 23e. Did | tobacc | o use contribute t | o the cause of death? | |
| ds, | signed be del | d by | Fait ii. Other significant conditions | contributing to deat | 11 501 1101 1930 | nting in the a | noonying c | auso giv | on an anti- | • | | | | robably 4 QUnknown | |
| COT. | been si should | Completed | | | | | | | | | 24a. Wa | s an | 24b. Were a | utopsy findings available | |
| Re la | te has age 2 | dwo | | | | | | | | | | opsy formed | ? death? | completion of cause of | |
| ital | certificate rector, pa | Be C | 25. Was case referred to medical examiner? | | | | | | 26. Place | e of Death | (Check only | | | | |
| of V | n. After this certificate ha funeral director, page | 유 | 1 ☐ Yes 2 ☐ No | Hospital: 1 Inp | | ER/Outpatier | | | 4 🗆 NI | | | | 6 QOther (Spe | ocity) /105/112 | |
| on C | h. After funera | tlon: | 27. Manner of Death 1. Natural 5 ☐ Pending investigation | 28a. Date of I (Month, | Day Year) | 28b. Time o Injury | r z | 8c. Injur Wor | yat k? Yes 2 □ | | 28d. Describe | now in | njury occurred | | |
| Division of Vital Records, or Attanding Physician: The law requires t. | death | fica | 3 ☐ Suicide 6 ☐ Could not b | 28e. Place of | Injury - At ho | me, farm, sti | | | | | 28f. Location | (Street | and Number or F | ural Route Number, | |
| Į Š | s after | Certification: | 4 Homicide determined | building, | , etc. (Specify | ") | | | | | City or To | OWII, SI | ate) | | |
| lospit | within 24 hours after death. To the Funaral Director: A completely filled in by the fu | edical | (Check only 2 Medical Exa | hysician: To the be miner: On the basi | s of examinat | wledge, deat | h occurred vestigation | at the tir | ne, date ar pinion, dea | nd place, ath occurr | and due to the | e cause e, date a | (s) and manner a and place, and du | s stated. e to the cause(s) | |
| the t | thin 24 | Med | 29b. Signature and title of certifier | and manner | r stated. | | 290 | c. Licens | e number | | | 29d. I | Date signed (Mon | th, Day, Year) | |
| ۴ | ≥ 0 2 0 | | | MO | | | | | 511 | 32 | | | 11-8- | | |
| | | | 30. Name and address of person who | completed cause | of death (Item | 23a) (Type, | Print) | | | | | | | | |
| | | | Jorge H. Abrego, | | | |)rive | St | . 104 | , Eas | ston, I | MD | 21601 | | |
| | Sta | ite | 31. Date filed (Month, Day, Year) | 2006 32. 29 | istrar's Signa | ture | 1 - 4 | , | | | | | | | |

| | | 1 | For State Registrar | State of M | • | partment ertificate | | and Mental I | lygiene Reg. No | UUb | 37717 |
|------------|--|------------------|---|--|---|--|------------------------|---|--------------------------------|--------------------------------|---------------------------------|
| | Physicia /Medic | an al | 1. Decedent's Name (First, Middle RANCES | R. M | OTTI | | | 2. Date of Month | OS Day | 2000 | 3. Time of Death 22/0 M |
| | Examin | er | 4a. Facility Name (If not institution | | | | own, or Location | n of Death | | County of Deat | |
| , e-41 | Funeral. | | ANNE ARUNDEL 1 5. Social Security Number | | EK ge (In yrs. last birthd | ay) If Under 1 | | er 24 Hrs. 8. Date of | Birth | NE ARUN 9. Birt | nplace (State or Foreign |
| | Funeral Director | | 214-10-7138 | 1□M 200 F | 91 Yrs | Months | Days Hours | Min. (Month) | Day, Year) | | AWARE |
| 1400 | pc , | | Usual Residence of Decedent | | 10c. City, Town o | r Lanation | | | | | 10d. Inside City Limits |
| | shov | 5 | 10a. State 10b. County | | | | | | | | 1X Yes 2 No |
| | the M | Director | MARYLAND ANNE | ARUNDEL | GLEN BU | 10f. Zip C | Code | | 10g. Cit | izen of What Co | untry? |
| | 3a or | | 1012 LILAC LAN | E | | 210 | 061 | | | S | |
| | within 72 hours after death with the Maryland ene. Than "naturel", or items 23a or 28a-f show he Medical Examinar must be notified at | Funeral | 11. Marital Slatus | 12. Was Decedent Armed Forces | Ever in U.S. | | | Origin? (Specify Yes o can, Puerto Rican, etc. | | 14. Race - Ame Black, White | |
| 9 | after or its | Fu. | 1 Never Married 2 Mar | med 1 ☐ Yes 2 ☐ A | No | 1 Tes, specii | | | <i>'</i> | | HITE |
| 93 | urel', | d by | 3 X Widowed 4 □ Divorced | Year or Dates: | | | | | 10h K | | |
| 15- | n 72 l | lete | (Specify only highe | nt's Education est grade completed) | - (C | ecedent's Usual Sive kind of work fe. DO NOT use | done during m | ost of working | 16D. K | ind of Business/ | industry |
| 21215-0036 | filed withi Hygiene. other than | Completed | Elementary/Secondary (0-12) | College (1-4or | | HOMEMAKI | ER | | N | ONE | |
| | e filed al Hygie other | Bec | 17. Father's Name (First, Middle, | | | | 18. Mo | ther's Name (First, Mic | | Sumame) | |
| <u>Jar</u> | 2 should be and Mental is marked o | 10 | HARVEY E. ROBEI | RTS | | | | PEARL HE | | | |
| Maryland | and and sum | | 19a. Informant's Name/Relations | | | 10023 | | nber or Rural Route Ni | eneme ne | | |
| | 1 and 2 Health tem 27 i | | DOROTHY ANN WII | LSON/ DAUGHT | ER 813 20b. Place of D | | | H, ARNOLD, | | 1012-13 ocation - City or | |
| Baltimore, | | | 1 X Borial 2 Cremation | 3 Removal from State | HENLOPE | N MEMOR | | | | | |
| Ħ | 2555 | | 4 Donation 5 NOther (| 1, 1 | PARK CE | The state of the s | Address of Fa | 11-13-06 SERVICES, | | TON, DE | LAWARE |
| Ba | Dep Impo | | 1/13/10 | Milan 1 | 1 | | | K RD, MILL | | DE. 19 | 966 |
| | | | 23a. Part1. Enter the disease, o shock, or heart failure. Lis | or complications that cause | | | | | | 22. 19 | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | a | spiral | tion | | umou | | | Onset and Death |
| 1 | /Medical | ST ST | resulting in death) | Due to (or a | s aconsequence of) | 200 | // | | | | 180 |
| н | Examiner | _ | Sequentially list conditions, | b | C | OPU | | | | | geens |
| | ed sit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or a: | s a consequence of) | • | | | | | |
| | be executed sicien and burial-transit | хап | that initiated events resulting in death) Last | c Due to (or a | s a consequence of) | : | | | | | |
| 160 | ite be executed sysicien and ne burial-transit | calE | | | | | | | | | |
| 68 | | | | V | | | | | | | |
| Вох | eath certifica attending ph for use as th | M/UE | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcom | e of pregnancy 2 Petal death | 3 □Ectopic pre | gnancy | | | 23d. Date of del | ivery Day Year |
| | e deal he att | Sicia | in the past 12 months? 1 Yes 2 No | | at time of death | 5 Other (spe | | | - 4 | Month | Day 19a1 |
| P.O | The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it | by Physician/Med | 9 ☐ Unknown Part II. Other significant condit | ione contributing to death | but not resulting in t | ne underlying ca | use given in Pa | rt 23e. l | Did tobacco | use contribute to | the cause of death? |
| Š, | ires the signer of be d | i by | Part II. Other significant condit | 0000 | 1 Xia | | use giveir iii r a | | | | obably 4 □Unknown |
| Records, | w requir been si should | Completed | | | | | | 24a 1 | Was an | 24h Were au | itopsy findings available |
| Re | he fav | m | | | | | | | autopsy performed? | prior to death? | completion of cause of |
| Vital | | 0 | 25. Was case referred to medical | al | | - | 26 PI | 1 ☐ Y ace of Death (Check o | | 1 Tes | 2 No |
| > | Physician: this certificanal director, | To B | examiner? | Hospital: 1 Linpat | ient 2 ☐ ER/Outp | atient 3 DO | Other | Nursing Home 5 □ | | 6 ☐Other (Spe | cify) |
| n of | ng Ph ter th neral | | 27. Manner of Death 1 ☑ Natural 5 ☐ Pend | 28a. Date of In (Month, D | iury 28b. Tin ay Year) Inju | ne of 28 | lc. Injury at Work? | 28d. Desc | ibe how inju | ry occurred | |
| Sior | Attending r death. ector: After by the fune | catic | 2 Accident invest | tigation | | М | 1 ☐ Yes 2 | | | | |
| Division | or Att fter d lirect in by 1 | Certification: | 3 Suicide 6 Could 4 Homicide deten | minod 286. Place Oil | njury · At home, farm etc. (Specify) | i, street, factory, | office | | on (Street ai r Town, Stati | | ural Route Number, |
| | pital | | 29a. Certifier 1 Certify | ing Physician: To the bes | t of my knowledge | death occurred a | t the time, date | and place, and due to | the cause/s |) and manner as | stated |
| | To the Hospital or Attending Phy within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral | edical | | Examiner: On the basis and manner s | of examination and/ | | | | | | |
| | within To the | Me | 29b. Signature and title of certifi | $n \sim D$. | 1 | 29c. | License numb | er (20/ | 29d. Da | ite signed (Mont | h, Day, Year) |
| | | | MAN W | y 09ei | Mam | | 0 7 | 11438 | N | UVO | 1 2006 |
| | BA6 | | 30. Name and address of person | 1 - KENTIA | death (Item 23a) (T | Print) DEFEA | VSE AH | GHWAY AN | NA PUL | is MD7 | 1401 |
| | Sta Regist | ate rar | 31. Date filed (Month, Day, Yea. NOV 1 | 3 2006 32. Pgis | trar's Signature | Sperte | • | | | | |

MICHAEL PATVICK NATH 06-08351 UNKUNK

Please Type or Print in Black Indelible Ink

| NK UNK | | State of Maryland / Dep 1- For State Ce Registrar Ce | artment of He artificate of De | | | eg. No. 200 | 6 3771 |
|--|----------------|--|-------------------------------------|--|--------------------------------------|---|--|
| Physicia ledical Examin | n/ | Decedent's Name (First, Middle,Last) | | | 2. Date of Deat Month November | h | 3. Time of Death 1935 hrs |
| leuicai Examiii | ICI | Michael Patrick Nash 4a. Facility Name (if not institution, give street and number) | 4b. C | ity, Town, or Location | | 3, 2006 4c. County of Death | |
| | | North Veterans Highway and West Benfield Roa | | illersville | | Anne Arundel | |
| Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. 1 X M 2 F 44 Usual Residence of Decedent | | Under 1 Year If Under onths Days Hours | Min | th(MM/DD/YYYY) 9. Bir Foreig 8, 1962 Co | |
| any | | | y, Town or Location | | | | 10d. Inside City Limits |
| vlaryland 28a-f show 1 at once | ē | | Severna Pa | | | | 1 Yes 2 X No |
| th the Marylar 23a or 28a-f s notified at on | l Director | 10e. Street and Number 416 Ben Oaks Drive East | 10f | Zip Code 21146 | 10 | og. Citizen of What Coul USA | ntry? |
| 15-0036 filed within 72 hours after death with the Maryland Hygiene d other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once | Funeral | 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 No | If Yes, sp | pecify Cuban, Mexican | | White, etc. | can Indian, Black, |
| urs afte | d b | 3 Widowed 4 Divorced or Dates: 15. Decedent's Education (Specify only highest grade completed) | 16a. Decedent's Us | 2 No specify: sual Occupation (Give | kind of work done | Specify Whi 16b Kind of Business/I | |
| 6 n 72 hours an "natur ical Exam | Completed | Elementary/Secondary (0-12) College (1-4 or 5+) | | f working life. DO NOT | use retired) | Mr. J. J. | |
| -0036 J within 72 giene ther than ' | omo | 17. Father's Name (First, Middle, Last) | | .S. Navy | 's Name (First, Middle, N | Milit | ary |
| 21215-0036 Juld be filed within 7 Mental Hygiene Marked other than cevent, the Medica | Be | James Joseph Nash | | | tricia McEv | <i>'</i> | |
| MD 21215-0036 d 2 should be filed within 721 th and Mental Hygiene n 27 is marked other than " umatic event, the Medical I | ٢ | 19a. Informant's Name/Relationship (Type, Print) Lori A. Nash/Wife | 110 | | | ber, City or Town, State | |
| re, MD 2 1 and 2 shou Health and P fitem 27 is r | | 20a. Method of Disposition 20b. | Place of Disposition (| | Date Date | 20c. Location - City or | k, MD 21146 Town, State |
| Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and I important: If item 27 is nijury or other traumarit. | | 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify 21 Ignature of Funer Survice Licens e | etro Crema | · | Nov. 8, 2006 | Baltimore | e, MD |
| Ba Perm Depa Impo | 1 | Some & Dellana |) Barra | anco & Son | s, P.A. Se | verna Park verna Park | Funeral Hom |
| Physician /Medical ˈxaminer | A | a. art I. Enter the disease, or complications that caused the death failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries | n. Do not enter the mo | ode of dying, such as c | ardiac or respiratory arre | est, shock, or heart | Approximate Interval Between Onset and Death |
| Vailillet | 4 | or condition resulting in death) Due tc (or as a consequence of | uf): | | | | |
| | ne | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | of): | | | | |
| - | Examine | (Disease or injury that initiated events resulting in death) Last | of): | | . | | |
| xecuted 1 and - transit | | d | | <u> </u> | | | |
| 760, cate be ex physician he burial | Medical | UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pret | nancy | | | 23d Date of delivery | |
| lox 687 eath certific | Physician// | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown | 2 Fetal de | | c pregnancy | 1 | ay Year |
| | | Part II. Other significant conditions contributing to death but not | resulting in the underl | lying cause given in Pa | art I. 23e, Did to | bacco use contribute to | he cause of death? |
| - s .5 .9 | ed by | | | | | 2 No 3 Prob | |
| Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by the funeral director, page 2 should be detached in by the funeral director, page 2. | Completed | | | | 24a. Was a autops perfort | prior to o med? death? | opsy findings available ompletion of cause of s |
| tal Fician: | Be | 25. Was case referred to medical examiner? Hospital: 4 I least at 3 | 7 | 26. Place of Death | | | |
| of Vit ling Physic After this | <u>ا</u> ي | 1 V Yes 2 No I Inpatient 2 2 27. Manner of Death 28a. Date of Injury | ER/Outpatient 3 28b. Time of Injury | DDA Other 4 28c Injury at Work | | Residence 6 Other | Scene |
| Sion (Attending death. setor: Af | cation | 1 Natural 5 Pending Nov 3, 2006 2 ✓ Accident Investigation | 1932 hrs | 1 Yes 2 | No Driver of aut | o involved in collsi | |
| Division of Vital I Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifi felled in by the funeral director, | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Injury - At P (Specify) Major Roa | | tory, office building, et | or Town, St | treet and Number or Rur ate) ghway and W. Bensf | |
| Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director: | Medical | 29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated. | | | | | |
| | Σ | 29b. Signature and title of certifier | | O.C.M.E. | | November 4, 200 | |
| 15 | | 30. Name and address of person who completed cause of death (Iter Jack Titus MD. Deputy Chief Medical Examine | | treet, Baltimore, I | MD 21201 | | |
| Sta Registr | | 31. Date filed (Month, Day, Year) 32. Registrar's Signat NOV 0 8 2006 | ure & Local | | | | |
| DHMH 17 Rev 1/200 | _ | THE WAY OF THE PARTY OF THE PAR | ORIGINAL | | | | |
| COLUE COCC | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - Statemend #5 Per FH G863 1/09/07 JH Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Jon Walen Ogland 4, 2006 12:00p Nov. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel 8430 Woodland Road Millersville 5. Social Security Number If Under 1 Year | Il Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1X M 2 ☐ F 92 Yrs. Director 217-34-6956 23. 1914 Norway Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at Anne Arundel Millersville 1 ☐ Yes 2 ☑ No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21108 USA 8430 Woodland Road Funeral 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Aerospace Engineer Westinghouse 5+ h and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I int: If Item 27 is marked o Marga Walen Olaf Johan Ogland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Aagot Marga Tucker/Daughter 9 Moore Rd. Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 11, 1 ☐ Burial 2 X Cremation 3 ☐ Removal Irom State permit. Page Department o Important: if any injury or gnce. Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Gov. Ritchie Hwy. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate 4 4 1 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Jemen Aco Y were's /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physicien be detached for use as the buria Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 □Ectopic pregnancy Month Day Y ear 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2/10 No 3 ☐ Probably 4 ☐ Unknown 1 Yes peeu 24a. Was an autopsy performe 24b. Were autopsy lindings available prior to completion of cause of death?
1 □ Yes 2 □ No has 2 No certificate 1 Yes Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death 2 Accident Diractor: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C To the Hospital 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 11-7-06. Name and address of person who completed cause of death (Item 23a) (Type, Print) Crofton Mirza Nusairee MD

DHMH 17 Rev 1/2001

State

Registrar

Hen necle Col

32. Registrar's Signature

10

MOV 0

9 200b

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) Day Physician NOV. 7, PATTERSON SR. 2006 2:10 P THOMAS /Medical 4h City Town or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES PRINCE GEORGES GENERAL HOSPITAL CHEVERLI

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Y)
JAN. 28, CHEVERLY 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Year) 1**%** M 2□ F 81 Yrs. FLORIDA 578-38-3145 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d, Inside City Limits id other than "naturel", or items 23a or 28e-f show event, the Medical Examinar must be required at 1 ∑Yes 2 No Director MD. PRINCE GEORGES HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20784 U.S.A. 6910 FARRAGUT ST. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Amed Forces: 1 MYes 2 □ No If Yes, Give Year or Dates: WWII 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BAKER WONDER BREAD CO. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked STELLA S. PATTERSON Μ. ျှ EDWIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages I and Department of Health an importent: If item 27 is 6910 FARRAGUT ST., HYATTSVILLE, MD. 20784 PATTERSON/WIFE TWILA R. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY NOV. 9, 2006 RIVERDALE, MD. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, 5801 CLEVELAND AVE., RIVERDALE, MD. hambusa M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARRHYTHMIA CARDIAC fmmediate Cause (Final disease or condition resulting in death) FATAL **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the SB esn IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year ō Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient ٩ 3□ DOA this the Funerei Director: After the 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of oxamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 100 29b. Signature and title of certified 29c. License number ress of pe who completed cause of death (Item 23a) (Type, Print) 30. Name and add CHEVERLY, MD 20785 3001 HOSPITAL GARY L egistrar's Signature 31. Date filed (Month, State 2006 0 9 Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 37721

| | | 1- For State Registrar | | | Ce | rtificate c | f Death | | | | | Reg. No | D. | | |
|--|----------------|--|---|--|------------------------|-----------------------------|--|---------------|-------------------------|-------------|-------------------------------|----------------------|-----------------------|--------------|--|
| Physicia ledical Exami | an/ | Decedent's Name (First, I | | Pavlo | vich | | | | | | Date of De Month Novemb | eath | | ır | 3 Time of Death 0831 hrs |
| | | 4a. Facility Name (if not insi Holy Cross Hospit | | eet and nur | mber) | | 4b. City, Tov Silver S | | cation of [| Death | | | lc. County of Montgon | | |
| Funeral Director | | 5 Social Security Number 182-14-7341 | 6. Sex | 2 X F | 7. Age (In yrs | last birthday) 85 Yr | If Under Months | | If Under 2 Hours | Min | 8. Date of E | | | | hplace (State or ⁿ Pennsylva untry) |
| Aaryland 28a-f show any 1 at once. | Director | Usual Residence of Decede 10a. State 10b. Co. Maryland Mo 10e, Street and Number | | cy | 10c. City | , Town or Loca | | ig ode | | | | 10g Ci | itizen of Wh | at Cour | 10d Inside City Limits 1 Yes 2 No |
| th the Maryland 23a or 28a-f sho notified at once. | | 819 Dennis | | | | | 2 | 0901 | | | | | | JSA | |
| 215-0036 be filed within 72 hours after death with the Maryland nntal Hygiene rked other than "natural", or items 23a or 28a-f shr ent, the Medical Examiner must be notified at once | by Funeral | 11. Marital Status 1 Never Married 2 3 Widowed 4 4 | X Married 1 | Armed Fo Yes es, Give Year Dates: | 2 X No | 1 | as Decedent Yes, specify (| uban, M | exican, Pi | uerto Ri | can, etc.) | | White Specify: | , etc Wh | ite |
| Baltimore, MD 21215-0036 permir Pages I and 2 should be filed within 72 hours a Department of Health and Mental Hygiene Important: If item 27 is marked other than "natura injury or other traumatic event, the Medical Examin | Completed | 15. Decedent's Education Elementary/Secondary (0 | | College (1- | | during r | nt's Usual Oc nost of workir Iomemak | g life. DC | | | | 166. | Kind of Bu | | Home |
| 215-0036 be filed within 7 ral Hygiene rked other than ent, the Medica | S | 17 Father's Name (First, Mi | ddle, Last) | | | 1 | ·· | 18. | Mother's N | Name (F | irst, Middle | , Maide | n Surname) | | |
| 2121; ould be fil Mental F marked ic event, | To Be | John Chupk 19a. Informant's Name/Rela | | Print) | | 19b. Maılir | ig Address (| Street an | | | artko al Route Ni | umber, (| City or Towr | n, State, | Zip Code) |
| , MD 21 and 2 should ealth and Me em 27 is ma raumatic ev | | Anthony Pavl | ovich/ | Husba | | 1.0 | Dennis | Ave | nue, | Sil | | Spri | .ng, M | D 20 | |
| Baltimore, MD 21215-003 ermi Pages I and 2 should be filed withi Department of Health and Mental Hygiene Important: If item 27 is marked other th injury or other traumatic event, the Med | | 1 Burial 2 Crem 4 Donation 5 X Other | er <i>Specify:</i> e | | m State | crematory or o utler Cou | ther place) Inty Mem | orial | N Park | oven 2 | nber : | 13 _B | utler | . Pe | ennsvlvania |
| Balti permit Departr Import injury | | 21. Signature of Funeral Se | vice Licensee | يحاكر | | ²² F 5 | Name and Ad rancis 00 Uni | oress of vers | Facility Coll ity | ins Blvd | Fune: | ral Sil | Home ver S | Inc. pri | ng, MD 2090 |
| Physician /Medical | | 23a. Part I. Enter the diseas failure. List only one c Immediate Cause (Final dis | ause on each li | ine. | | n. Do not enter | the mode of o | ying, suc | ch as card | liac or re | spiratory a | rrest, sh | ock, or hea | rt | Approximate Interval Between Onset and Death |
| Examiner | | or condition resulting in dea | | | consequence | | 30030 | | | | | | | | ! |
| | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca (Disease or injury that initia | ed c | | consequence (| | | | | | | | | | |
| ecuted and transit | | events resulting in death) L | ast Due | to (or as a | consequence (| of): | | | | | | | | | |
| 760, cate be ex physician he burial | edical | UNPENDED | AM | MENDED | | | | | | | | | | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the contraction. | ≥ | IF FEMALE: 23b. Was decedent pregnan past 12 months? 1 Yes 2 No 9 ✔ | in the 1 | Live bi | ant at time of d | 2 Fe | etal death ther <i>(Specify</i> | | Ectopic pr | egnancy | / | 23 | Bd Date of a Month | | ay Year |
| ires that the c signed by th | by P | Part II. Other significant co | nditions con | ntributing to | death but not i | resulting in the | underlying ca | use giver | n in Part I | | | | | The O | he cause of death? |
| Division of Vital Records, tal or Attending Physician: The law require rs after death al Director: After this certificate has been sited in by the funeral director, page 2 should be | Completed | | | _ | | | | | | _ | 24a. Was auto perf | opsy ormed? | pr de | | opsy findings available ompletion of cause of |
| tal Rec ian: The certificate ector, page | ادہ | 25. Was case referred to me | dical | | | | 26. | Place of I | Death (Ch | neck only | | | | V 10. | 2 140 |
| Vit; | To B | examiner? 1 ✓ Yes 2 No | Hospi | 1 11 | | ER/Outpatien | t 3 DOA | Oth | er ₄ N | ursing H | lome 5 | Resid | ence 6 | Other: | |
| on of ending Pl ath or: After he funera | tion: T | | Pending | 28a. Date o (Month, | of Injury Day,Year) | 28b. Time of | · · | Injury at | t Work? | - 1 | d. Describe | how in | jury occurre | d | |
| Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the | Certification: | 3 Suicide 6 | Investigation Could not be determined | 28e. Place (Specify) | of Injury - At h | nome, farm, stre | et, factory, of | fice build | ling, etc. | 28 | f. Location or Town, | | and Numbe | r or Rur | al Route Number, City |
| the Hosp hin 24 hor the Fune | Medical C | 29a. Certifier (Check only) Certifyii | Examiner: On | the basis o | f examination a | dge, death occu | | | | | | | | | |
| To Wit | Mec | 29b. Signature and title of ce | | manner st | ated | | 29c. L | cense nu | umber | | - | 29d. | Date signe | d (Mon | th, Day, Year) |
| 5 | | aus |) ' | | | 00.) | C | C.M.E | ≣. | | | No | vember 8 | 3, 200 | 6 |
| | | 30. Name and address of pe | Assistant M | nedical E | xaminer | 111 Penn | Street, Bal | timore, | MD 21 | 201 | | | | | |
| St Regist | ate | 31. Date filed (Month, Day, Y NOV | 1 3 20 | 06 ^{32. Re} | strar's Signat | ure M | carle | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 9 John Colbert Pryor, III 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Lanham Doctors Community Hospital 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 5/10/47 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 59 Wash. D.C. 578-66-3615 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1√2 Yes 2 □ No Riverdale P.G. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20737 U.S.A. 5602 62nd Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 No Yes 2 No No If Yes, Give 66-170 Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Dept. of Engineering Elementary/Secondary (0-12) 12th College (1-4or 5+) Correspondence Administrator U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie Coleman John C. Pryor, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5602 62nd Ave., Riverdale, Maryland Betty Jo Pryor/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/18/06 Brentwood, Md Ft. Lincoln Cem. 22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 21. Signature of Funeral Service Licensee frate any 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Er ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DYSKHYTHMIN Due to (or as a consequence of): ACUTE CORDINARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1□ Yes 2□No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

LUCK RD LANHAM ma 26706

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Md.

Funeral Director

Be Completed by

2

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

death with the Maryland

Maryland

Baltimore,

es 1 and 2 should be of Health and Mental

Pages 1

= 5 permit. Page Department of Important: If any injury or once,

> the burial-tran as sign. be (page

Physician/Medical Examiner Completed by

Medical Certification: To Be

the death certificate be executed funeral After within 24 hours after death To the Funeral Director:. completely filled in by the

Division or Vital Records, P.O. Box 68760,

Va

State Registrar

SHOBHUT 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Sholk

1 ☐ Yes 2 ☑ No

5 ☐ Pending investigation

6 ☐ Could not be

27. Manner of Death

1 Natural

3 ☐ Suicide

2 Accident

4 Homicide

(Check only one)

NOV 13 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8118 32. Registrar's Signature

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient

28a. Date of Injury (Month, Day Year)

3□ DOA

28c. Injury at Work?

1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

20054675

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

| | | | For State Registrar | State of | f Marylar | | artment of H | | d Menta | l Hygier | 2000 | 37723 |
|----------------|---|------------------|--|--|--|-----------------------|---|---------------------|-------------------------|--|-----------------------------|--|
| | | | Decedent's Name (First, Middle, L. | ast) | | | | | | e of Death | | 3. Time of Death |
| | Physici /Medic | | CHRISTOPHER | | PETROU? | ΓSA | | | NOV | 2, | 2006 Year | 4:42 p ^M |
| | Examin | | 4a. Facility Name (If not institution, g | | | | 4b. City, Town, or | Location of D | Death | | 4c. County of Dea | |
| | | | Southern Maryla | | | fact high do at | Clinto | n If Under 24 | Hre la - | | Prince G | |
| ľ. | Funeral Director | | 5. Social Security Number 6. 577-42-6007 | Sex 1∭XM 2☐F | 7. Age (In yrs. 63 | Yrs. | Months Days | | Min. (Mo | e of Birth onth, Day, Yei -22-19 | | thplace (State or Foreign ountry) hington, DC |
| | | | Usual Residence of Decedent | | | | | | 01 | 22-17 | TJ Was | nington, bc |
| | urylan show | _ | 10a. State 10b. County | | | ty, Town or Lo | | | | | | 10d. Inside City Limits |
| | Ba-f | ecto | | George's | 3 | Clint | | | | | | 1 ∑Yes 2 □ No |
| | with t | 2 | 10e. Street and Number 9211 Stuart Lane | | | | 10f. Zip Code 207 | 735 | | 10g. | Citizen of What C U.S.A. | ountry? |
| | death ms 23 | Funeral Director | 11. Marital Status | | dent Ever in U | l.S. 13. \ | Was Decedent of Hi f Yes, specify Cuba | | i? (Specify Ye | s or No- | 14. Race - Am | |
| 36 | within 72 hours after death with the Maryland ene. than "retural", or terms 23a or 28a-f ehow than fredical Exactinat must be notitied at | by Fur | 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | Armed For 1 Tyes If Yes, Giv Year or Do | 2 📉 No e | | f Yes, specify Cuba 1 □ Yes 2🛣 No | | uerto Rican, | etc.) | Black, Whi | |
| 21215-0036 | 2 hou | ted | 15. Decedent's I | Education | 163. | 16a. Dece | ient's Usual Occupa | ation | | 16b | . Kind of Business | s/industry |
| 215 | thin 7: 9. An "n | Completed | (Specify only highest g Elementary/Secondary (0-12) | rade completed) College (1 | -4or 5+) | | kind of work done of OO NOT use retired | during most of) | f working | Ur | nited Cen | rebra1 |
| 2 | ygien ygien rt, tte | Con | Special Edu. | | | рау | Program | | | | Pa1sy | |
| and | id be fit ental H ked oth ic even | To Be | 17. Father's Name (First, Middle, Las Peter J. Petrout | | | | | | Name (First, a Manos | | len Sumame) | |
| Maryland | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "netural; or Items 23a or 28a-f show envi fujury or other traumatic event, the Medical Examinational Depending at ODGE. | - | 19a. Informant's Name/Relationship Kenneth A. Pitt | | anager | | ng Address (Street a | | | | y or Town, State, | |
| Baltimore, | es 1 a of Hee f Item r othe | | 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 | □Pomoval from t | | Place of Dispo | sition (Name of natory or other plac | θ) | Date | 20c. | Location - City or | Town, State |
| Ĕ | Pag ment ant: It ury o | | 4 Donation 5 Other (Spec | | | | Cemetery | | /14/20 | | shington | • |
| Ball | Depending Depending Support | | 21. Signature of Funeral Service Lice | Banan | CC 3 | | Name and Address 447 14th | | | | | ome, Inc. O.C. 20010 |
| | | | 23a. Part1. Enter the disease, or co shock, or heart failure. List on | nplications that cay one cause on e | aused the deat ach line. | th. Do not ent | er the mode of dyin | g, such as car | rdiac or respir | atory arrest, | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | _a Bil | atural | Mem | ari q | | | | | Onset and Death |
| | /Medical Examiner | | resulting in dealiny | Due to (| or as a consec | quence of): | | | | | | |
| | 1 2 3 | e | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (| UF as a sunsuq | uwnee of): | | | | | | - |
| | cuted nd ransit | Examiner | Cause (Disease or injury that initiated events | C | | | | | | | | |
| Ö, | cate be executed physicien and the burial-transit | | resulting in death) Last | Due to (| or as a consec | quence of): | | | | | | |
| 8760, | cate b physic the b | dlcal | | d | | | | | | | | |
| Вох 6 | that the death certification of the attending of detached for use as | n/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, out | | | _ | | | | 23d. Date of de | livery |
| Ö. | s death he atte ed for | Physician/Me | in the past 12 months? 1 ☐ Yes 2 ☐ No | | irth 2 ∐ Feta ant at time of c own | | Ectopic pregnancy Other (specify) | | | | Month | Day Year |
| P.O. | that the | Phy | 9 ☐ Unknown Part II₄ Other significant conditions | | | sulting in the u | nderiving cause give | en in Part I. | 23 | e. Did tobacc | o use contribute t | o the cause of death? |
| Vital Records, | The law requires that the death certificate has been signed by the attending page 2 should be detached for use as | Completed by | Anoxic Encylo | weating | | | | | | | | robably 4 🗍 Unknown |
| 000 | e law re has bee ge 2 sho | plet | | | | | | _ | 24: | a. Was an autopsy | 24b. Were a | utopsy findings available completion of cause of |
| <u> </u> | | Con | | | | | | | 10 | performed Yes 2 | death? | |
| Vita | Physician: Th this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | Hospital: | , | | . 0 | | Death (Check | k only one) | | |
| of | Phys r this ral dir | 5 | 1 ✓ Yes 2 ☐ No 27. Manner of Death | 28a. Date of | · | ER/Outpatien | | 4 110131 | | | 6 ☐Other (Spe | ecify) |
| Ö | Attending r death. ector: After by the funer | tlon | 1 Natural 5 ☐ Pending 2 ☐ Accident investigati | (Mont | h, Day Year) | Injury | Work | (? Yes 2∐No | | 30100 11011 | ijary occurred | |
| Division of | or Atter effer dea Director in by the | Certification: | 3 Suicide 6 Could not determine | d 28e Place | of Injury - At h | ome, farm, str fy) | eet, factory, office | | | ation (Street or Town, St | | ural Route Number, |
| _ | To the Hospital or Attending Ph within 24 hours eiter death. To the Funerel Director: After th completely filled in by the funeral | edical Co | 29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex | iminer: On the ba | isis of examina | ation and/or in | occurred at the time vestigation, in my op | oinion, death o | occurred at the | e time, date a | and place, and du | e to the cause(s) |
| | To the within 2 To the complet | Med | 29b. Signature and title of certifier | and manr | ier stated. | | 29c. License | number | | 29d. (| Date signed (Mon | th, Day, Year) |
|) | H 3 F 8 | | Kich | | | | 1)00 | 2551 | 120 | M | 2 √ 3 2 | 006 |
| R | (2) | | 39. Name and address of person who | completed caus | e of death (Iter | п 23а) (Туре, | Print) Jufe | 17.0 /. | Jan bish | chia. | 00 2190 | / 2) |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32. R | egistrar's Signa | ature _ | VU VUR | JIV | - ~ / V O (P) | J run | | 36 |
| | Registr | | NOV 1 3 2006 | Bereit | 1. | Speed | 9 | | | | | |

Box 68760. P.O. Division or Vital Records. Hospital 24 hours completely

altimore, Maryland 21215-0036

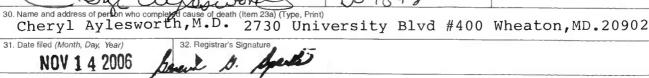
within 24 the

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State Registrar

(Check only

29b. Signature and Wile of certifier



NOV 1 4 2006

29c. License number

1)54378

29d. Date signed (Month, Day, Year) Nov.9, 2006

| 06-08554 | Please Type or Print in Black Indelible Ink | |
|---|--|--|
| lohn William Rashli | 1- For State Certificate of Death | giene 2006 37725 |
| Physician/ | Registrar 1. Decedent's Name (First, Middle,Last) | 2. Date of Death 3. Time of Death |
| Medical Examiner | JOHN WILLIAM RASHLICH | Month Day Year November 9, 2006 2207 hrs |
|) | 4a. Facility Name (if not institution, give street and number) Southern Mayland Hospital Center 4b. City, Town, or Location of Death Clinton | 4c. County of Death Prince George's |
| Funeral | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or |
| Director | 204-34-7105 1XM 2F 61 Yrs. Months Days Hours Min. | May 21, 1945 Foreign Country) PA |
| any | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | 10d. Inside City Limits |
| * . | Maryland Prince Georges Upper Marlboro | 1 X Yes 2 No |
| Maryland 28a-f show 1.at.once. ector | 10e. Street and Number 10f. Zip Code | 10g. Citizen of What Country? |
| rith the Maryland s.23a or 28a-f shov inotified at once. | 9821 Dorval Ave. 20772 | United States |
| with 1 s 23s e not | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp | |
| r death with or items 23 must be no | 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No | Rican, etc.) White, etc. |
| safter or ural", or niner m | 3 Widowed 4 Divorced of Society Year Vietnam 1 Yes 2 X No specify: | Specify White |
| natura xami | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w | ork done 16b. Kind of Business/Industry |
| 6 n 72 h cal E | Elementary/Secondary (0-12) College (1-4 or 5+) | eu) |
| 5-0036 ed within 72 hour tygiene other than "natt the Medical Exar Completed | 1 Building Management | U.S. Government |
| 21215-0036 Id be filed within 72 hours after dental Hygiene. narked other than "natural", event, the Medical Examiner o Be Completed by | | (First, Middle, Maiden Surname) |
| | TABILITE TO THE PARTY OF THE PA | Grace Smithbower ural Route Number, City or Town, State, Zip Code) |
| A MD 2 show lealth and 2 show tem 27 is retraumatic | | per Marlboro, MD 20772 |
| e, N and Health item | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, | Date 20c. Location - City or Town, State |
| TOTE ages 1 in of F it: Hi other | 1 XBurial 2 Cremation 3 Removal from State 4 Departion 5 Other Specify 11/ | 1//2006 Phonoh D |
| Iltin nit P artme ortan | - I - I - I - I - I - I - I - I - I - I | 14/2006 Ebensburg, Pennsylvani |
| Deprin Deprin | , // | ouffer Funeral Homes, P.A. Pike/ Frederick, MD 21702 |
| Physician | 23 Pm Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or | respiratory arrest, shock, or heart |
| /Medical | tailure List only one cause on each line. Immediate Cause (Final disease a. Shotgun Wound to back | Between Onset and Death |
| Examiner | or condition resulting in death) Due to (or as a consequence of): | |
| _ | Sequentially list conditions, b. | |
| red nsit | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause C. | |
| xarr | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | |
| ecuted and transit | d | |
| | UNPENDED AMENDED | |
| D. Box 68760, the death certificate be expyrite attending physician ched for use as the burial Physician/Medic | IF FEMALE: 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
| certify certify sanding use as | past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregna | ncy Month Day Year |
| Boy death he atte d for i | 1 Yes 2 No 9 Unknown 9 Unknown | |
| that the detached detached | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? |
| i, P.C ires that signed to be deta | | 1 Yes 2 No 3 Probably 4 Unknown |
| Records, I The law requires fricate has been sig page 2 should be Completed | | 24a. Was an 24b. Were autopsy findings available prior to completion of cause of |
| Recol The law icate has page 2 sl | | performed? death? |
| tal Rection: The certificate ector, page | 25. Was case referred to medical 26 Place of Death (Check of D | 1 Yes 2 No 1 Yes 2 No |
| Vital hysician: this certiff I director, Co Be (| examiner? | g Home 5 Residence 6 Other: |
| of Vi ing Physi After this uneral dir in: To | 27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? | 28d. Describe how injury occurred |
| On endir sath. or: A | Pending Pending No | Subject shot |
| Division of Vital Records, P.O. Box 68760, not attending Physician: The law requires that the death certificate b its after death. To Director: After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the burstification: To Be Completed by Physician/Mec | 2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office building, etc. | 28f. Location (Street and Number or Rural Route Number, City |
| Division of ' Bospital or Attending Ph 24 hours after death. Funeral Director: After teely filled in by the funeral all Certification: T | determined | or Town, State) 9821 Dorval Avenue, Upper Marlboro, MD |
| 8 4 5 7 | 29a Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and | |
| To the Hos within 24 h To the Fun completely | one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated. | the time, date and place, and due to the cause(s) |
| 1 5 | 29b. Signature and title of certifier 29c. License number | 29d Date signed (Month, Day Year) |

30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

November 10, 2006

29d Date signed (Month, Day, Year)

State Registrar

| | | 1 | 1 - For Stata Registrar | State of N | Marylar | | artmen rtificat | | | nd Mental F | lygien Reg. N | 2006 | 37726 |
|----------------|---|---------------------|---|--|---------------------------|---|---------------------------|-------------------------|------------------------------|--|-------------------------------|---------------------------------------|---------------------------------|
| | in 100 miles | - | 1. Decedent's Name (First, Middle | , Last) | | | | | | 2. Date of Month | Death Da | ay Year | 3. Time of Death |
| | Physici /Medic | | Geraldean | Deloris | | F | Robins | | | Noveml | er 8 | , 2006 | 10:50 A M |
| | Examin | | 4a. Facility Name (If not institution | , give street and number | er) | | | | Location of | | | c. County of Deatl | |
| 7 | | | 2000 Wolf Street | C C 7 | Ann In um | last birthday) | | | hington | | | Prince Geo | rge's |
| | Funeral Director | | 5. Social Security Number 239–72–6740 | 6. Sex 7. 1 M 2 T F 6 | | Yrs. | Months | Days | Hours | Min. (Month, | Day, Year |) Co | h Carolina |
| | | | Usual Residence of Decedent | | | | | | | nug. | 10, 1 | JAJ MOIL | ii Carocina |
| | nylan how | _ | 10a. State 10b. County | 0 | 10c. C | ity, Town or Lo | | | | | | | 10d. Inside City Limits |
| | 8a-1 e | cto | | George's | | Ft. Was | | | | | | | 1 ☐ Yes 🏖 🔀 No |
| | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural', or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Eranical mouther routiled at ance. | by Funeral Director | 10e. Street and Number 2000 Wolf Street | | | | 10f. Zip | 207 | 44 | | | itizen of What Co SA | untry? |
| | r dea | neur | 11. Marital Status | 12. Was Decede Armed Force | s? | J.S. 13. | Was Deced | dent of Hi cify Cuba | spanic Orig n, Mexican, | in? (Specify Yes or Puerto Rican, etc.) | No- | 14. Race - Ame Black, White | |
| 36 | or li | Y. | 1 ☐ Never Married 2 🛣 Marr 3 ☐ Widowed 4 ☐ Divorced | ied 1 □ Yes 2] If Yes, Give Year or Date | | | 1 🗆 Yes | 2√∑ No | Specify: | | | Specify: B | lack |
| 21215-0036 | hour | | 15. Deceden | | 3. | 16a. Dece | dent's Usus | al Occupa | ation | | 16b. l | Cind of Business/ | ndustry |
| 15 | n "ng n "ng | piet | (Specify only highest Elementary/Secondary (0-12) | | or 5+\ | (Give | kind of wo DO NOT u | rk done d se retired | luring most) | of working | | | , |
| 21 | d with giene er the | Completed | Lienientary, decondary (5 12) | 2 | 51 547 | Self- | -empl | oyed | | | Со | nsultant | |
| p | al Hy d oth | Be (| 17. Father's Name (First, Middle, | | | | | | 18. Mother | 's Name (First, Mid | dle, Maide | n Sumame) | |
| <u>کا</u> | Meni Meni arrke | ဥ | | Galloway | | | | | Naon | | | | |
| Maryland | 12 sh and h 7 Is m raum | | 19a. Informant's Name/Relations Kenneth Robinson | | | | - | | | r or Rural Route Nu Washington | , | | |
| e, | 1 and Healt em 2 ther 1 | | 20a. Method of Disposition | Tiusbarid | 20b. | | | | | Date | | ocation - City or | |
| Baltimore, | nt of nt of t: # It | | 1 ☐ Burial 2 🖾 Cremation | | | Place of Dispo cemetery, crei alas Cr | | | 11 | 1/9/2006 | | ewater,M | |
| Ē | artme orten injury | | 4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service | | | | | - | c of Equilibri | , | | | |
| æ | Depa Impo eny is | | Jan P. K. | elso A' | | | | | | George P. I 1 Oxon Hill | | | |
| 2 | | | 23a. Part1 Enter the disease, or shock, or heart failure. List | complications that caus | sed the dea | | | | | | | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | | | Failur | re | | | | | | Onset and Death |
| | /Medical | | resulting in death) | Due to (or | as a conse | quence of): | | | | | | | |
| | Examiner | _ | Sectiontially list conditions if any, leading to immediate | b | | Colon | Cance | er | | | | | |
| | ed sit | nine | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | To) or aud | as a conse | quence oi): | | | | | | | |
| | be executed icien and burial-transit | Examiner | that initiated events resulting in death) Last | c. Due to (or | as a conse | quence of): | | | | | | | |
| 760, | ate be executed hysicien and he burial-transit | cal | | d | | | | | | | | | |
| 89 | leath certificat attending phy I for use as th | | | | | | | | | | | | |
| Вох | death certifica e attending ph d for use as th | an/N | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcom | | | Ectopic p | regnancy | | | | 23d. Date of deli | • |
| Э. | 0 0 0 | Physician/Med | in the past 12 months? 1 ☐ Yes 2 ☎ No 9 ☐ Unknown | 4☐ Pregnan 9☐ Unknown | t at time of | | Other (sp | pecify) | | | - | Month | Day Year |
| P.O. | that the ed by detact | | Part II. Other significant condition | Ms contributing to deat | h hut not ra | sulting in the u | nderlying (| cause and | on in Part I | 23a D | id tobacco | use contribute to | the cause of death? |
| Vital Records, | es De | d by | Hypertensio | • | | | - | | | | | | obably 4 Unknown |
| CO | law requir as been si 2 should | Completed | | | | | | | | 24a. W | | 24b. Were au | topsy findings available |
| æ | The la ate ha page 2 | E | | | | | | | | pe | itopsy erformed? s XX N | death? | ompletion of cause of |
| ita | | Be C | 25. Was case referred to medica examiner? | | | | | | 26. Place | of Death (Check on | | | |
| o | S D | 10 | 1 ☐ Yes 2 No | Hospital: 1 ☐ Inp | atient 2 | ER/Outpatier | nt 3 DC | Othe Othe | er: 4 □ Nur | sing Home 5X R | esidence | 6 □Other (Spec | eify) |
| ם | | ë. | 27. Manner of Death 1 ⊠Natural 5 □ Pendir | 28a. Date of I (Month, | njury <i>Day Year)</i> | 28b. Time o Injury | | 28c. Injury Work | at c? | 28d. Descri | | ury occurred | |
| sio | E E E | cati | 2 Accident investi 3 Suicide 6 Could | gation | Indiana AAA | | М | | Yes 2□N | | n /Ctrant n | nd Number or Du | ral Route Number. |
| Division | l or Atten efter deat Director: | Certification: | 4 ☐ Homicide determ | ined 286. Place of building, | etc. (Spec | nome, farm, sti ify) | reet, ractor | у, опісе | | | Town, Sta | | rai Addie Number, |
| _ | To the Hospital or Atterviewithin 24 hours effer de To the Funersi Directo completely filled in by the | Medicai C | 29a. Certifier 1 ☑ Certifyir (Check only 2 ☐ Medical | ng Physician: To the be Examiner: On the basi | est of my kn | owiedge, deat alion and/or in | h occurred vestigation | at the tim | ie, date and pinion, deat | d place, and due to the time of the time. | he cause(: ne, date ar | s) and manner as nd place, and due | stated, to the cause(s) |
| | othe ithin 2 o the ample | Meo | one) 29b. Signature and title of certifie | and manner | stated. | | 29 | c. License | number | | 29d. D | ate signed (Monti | n, Day, Year) |
| | T WE TOO | | 1/1. | 11. | X. | .0.0.4 | | 0055 | | | | | |
| Λ | (12) | | 30. Name and address of person | who completed cause | of death (Ite | m 23a) (Type. | Print) | | | | TNOVE | ember 8, | 2000 |
| 12 | 110/ | | Eugene C. Taylo | | | | | and, | Md. | 20746 | | | |
| 20 | Sta | | 31. Date filed (Month, Day, Year) | | | lature perti | | | | | | | |
| | Regist | ral | MA TO SOL | Decer . | N. | Maria | | | | | | | |

Veronica Ramsamos Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Funeral Director

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mentel Hygiane. Important: if item 27 is marked other than "naturel", or items 23a or 28e-f show eny injury or other treumatic event, the Madical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be associted within 24 hours effer deeth.

To the Funeral Director: After this cartificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be datached for use as the burial-transit Division of Vital Records, P.O. Box 68760.

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | State of | of Maryland / D | epartm <i>Certific</i> | | | and M | | | | 7707 |
|--|---|---------------------------------|---|---|--------------------------|---------------------|--------------|--------------------------------|---------------------------|---------------|---|
| | 1 Decedent's Name (First Middle Lee | 41 | | Ceniiic | cate of | Deam | | | Reg. No. | 0 | 31121 |
| an | Decedent's Name (First, Middle, Las | | | | | | | 2. Date of De. | Dev | Year | 3. Time of Death |
| al | Veronica Rams 4a Fecility Neme (If not institution, give | samooj | | | | 45 City To | um or l or | Cation of Death | | 006 | 5230 AM |
| er | | | , | | | | | | | | |
| | Layhill Center / 5. Social Security Number 6. Se | | LS Healthca: 7. Age (In yrs. last birti | | nder 1 Year | S11V | | ring 8. Date of Birl | | gomery | |
| | | | 73 | Mor | ths Days | Hours | Min. | (Month, Da | y, Year) | Counti | ace (State or Foreign Trinidad, |
| | Usual Residence of Decedent | | / 3 | | |] | Ψ | uly 02 | , 1933 | West | Indies |
| | 10a. Stete 10b. County | | 10c. City, Town | or Location | | | | | | 10 | d. Inside City Limits |
| ģ | Maryland Montgon | nery | 01ney | | | | | | | | 1⊠ Yes 2□ No |
| <u>F</u> | 10e. Street end Number | | | 10f | . Zip Code | | | | 10g. Citizen of | Whet Count | ry? |
| ai | 17317 Monitor Dri | ive | | | 20832 | | | | United | State | 25 |
| Be Completed by Funeral Director | 11. Marital Status | 12. Was Dec | edent Ever in U,S. | 13. Was D | ecedent of I | lispenic Ori | gin? (Spec | cify Yes or No lican, etc.) | - 14. Rac | ce - America | |
| 3 | 1 Never Married 2 Married | 1 ☐ Yes If Yes, Gi | 2 🔯 No | | s 2 No | Specify: | i, r donto i | ticari, otc.) | Specif | | ic. |
| d D | 3 ☑ Widowed 4 ☐ Divorced | Year or D | | | | | | | Specin | Black | ζ |
| ete | 15. Decedent's Edu (Specify only highest grad | ucation de <i>completed)</i> | 16a. I | Decedent's ((Give kind o life. DO NO | Usuel Occur work done | ation during mos | t of workin | g | 16b. Kind of B | usiness/Indu | ustry |
| mp | Elementery/Secondary (0-12) | College (| 1-4or 5+) | | | 3) | | | | _ | |
| ပ္ပ | 12 17. Father's Name (First, Middle, Last) | | | Careg | iver | 19 Mothe | r'e Name | /First Middle | Elde: | r Care | 2 |
| Be | | | | | | | | | | 10) | |
| ٥ | Conal Thomas 19a. Informant's Name/Relationship (T | ima Print) | 105 | Adailian Add | leann (Ctan at | | | MacMil: | lian er, City or Town, | 01-1-7-0 | 2-4-1 |
| | Lynnette Jones / | | | | | | | | | | |
| | 20a. Method of Disposition | Daugni | 20b. Place of | | | Drive | 2; 01 | ney, Ma | aryland | | |
| | 1 ☐ Burial 2 ☐ Cremation 3 ☐ F | | State | , crematory | | , | | | | | |
| | 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens | | Ft. Lir | | Crema: e and Addre | | | /15/06 | Brentwo | ood, M | laryland |
| | 21. Signature of Purieral Service (Certs | 966 | | i | | | • | al and | Cremati | on Cer | nter |
| _ | J. J. | | | 1040 I | Rockvi | 11e P | ike, | Rockvi | .11e, Ma | rylan | d 20852 |
| | 23a. Part . Enter the disease, or comp shock or heart failure. List only o | ne ceuse on e | caused the death. Do no each line. | ot enter the | mode of dyir | g, such as | cardiac or | respiratory ar | rest, | - 1 | Approximate nterval Between Onset and Death |
| | Immediate Cause (Final | | 5005 | . < | | | | | | | |
| disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | |
| Je l | | | C | A is | :10 | In. | Pol | 1700 | 1 | 1 | |
| E E | Sequentially list conditions, if eny, leading to immediate | b | Due to (or as a co | nsequence | of): | . /[| / | | | | |
| dicai Examiner | at eny, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | | | | | | 1 | |
| dica | that initiated events resulting in death) Last | · | Due to (or as e co | nsequence | of): | | | | | | |
| Me | L. | d. | | | | | | | | i | |
| ig. | | | | | | | | | | l | |
| Ž | Part II. Other significant conditions con | | / | - | ng cause giv | en in Part I. | | 23b. Did t | obacco use co | ntribute to t | he cause of death? |
| Be Completed by Physician/Me | | II N | 1 en Tia | | | | | 101 | res 2□No | 3 Proba | bly 4 Unknown |
| Ö. | | | V | | | | | 24a. Wes a | an autopsy | 24b. Were | e autopsy findings |
| ete | | | | | | | | perfor | | avail | able prior to pletion of cause |
| 티 | | | | | | | | | H | | eath? |
| 3 | 25 Was some referred to medical | | | | | | | 1 U Y | 1 | 10 | Yes 21 No |
| | 25. Was case referred to medical examiner? | Hospital: | Inpatient 2 ER/Outr | | DO4 Oth | 00: 1/ | | (Check only or | | | |
| 0 | 27. Menner of Death | 28e. Date | of Injury 28b. Tir | | DOA 28c. Injur | et | | | ence 6 Oth | | |
| 0 | 1 Naturel 5 Pending 2 Accident investigation | (Mon | th, Dey Year) Inj | ury M | Wor | k? Yes 2∐1 | | | | - | |
| | 3 Suicide 6 Could not be | 28e. Place | of Injury - At home, farr | n, street, fac | tory, office | | 28 | 3f. Location (S | treet and Numb | er or Rurel I | Route Number, |
| | 4 ☐ Homicide | buildi | ng, etc. (Specify) | | | | | City or Tow | n, Stete) | | |
| Medical Certification: | 29a. Certifier 1 Certifying Phys | sician: To the | best of my knowledge, asis of examination end/ | death occur | red at the tin | ne, date and | place, an | nd due to the c | euse(s) and ma | nner as stel | ted. |
| 2 | one) | and man | ner steted. | | | | ——— | | | | |
| | 29b. Signeture and title of certifier | Hall | Chy Dly | Sicia | 29c. Licens | number 2 | 61 | | 29d. Date signed | (Month, Da | ay, Year) |
| - | I show or | 7046 | ~1.3/ | 7.000 | L | 15 2 | 04 | | NOV. | 00 | 006 |
| | 30. Name and address of person who co | 670 | 1 N. C/ | ype, Print) | les. | st. | 420 | 72 Ba | etim s | u 2 | 1204 |
| e r | 31. Dete filed (Month, Day, Year) NOV 1 3 20 | 006 32. | egistrer's Signature | April 1 | 0 | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State Registrar

| | | | 1 - State Registrar | | State of | Marylar | nd / Dep | artme | nt of H | | and M | | gien Reg. N | ne On c | 6 | 37 | 728 |
|----------------------------|--|---------------------|---|---------------------------|---|----------------------------|------------------|---------------------------|---------------|----------------------------|------------------------|--|----------------|-----------------------------|------------|--|--------------|
| 1 | Physici | an | Decedent's Name (First, | | , | | | | | | | 2. Date of De Month | D | ay | Year | 3. Time o | of Death |
| | /Medi | cal | John Garrett | | | | | | | | | November | | 2006 | | 6:30 | ам |
| - | Examir | ner | 4a. Facility Name (If not inst | | | ver) | | 4b. Cit | , Town, or | Location of | of Death | | 4 | lc. County of | of Death | | |
| | \$ (i.e.) | | Sunrise Assis 5. Social Security Number | ted Li | | Age (In ure | last birthday | | Freder | ick If Under | 24 Hrs | 0 D-1 (D) | -45 | Fr | eder: | | |
| | Funeral Director | | | | M 2□F | | Yrs. | Months | | Hours | Min. | 8. Date of Bir (Month, Da | ay, Yea | | | place (State ntry) | |
| | | | 579-24-0063 Usual Residence of Decede | nt | | 81 | | | | | | December | 24, | 1924 | Wash | nington, | , DC |
| | yland | | 10a. State 10b. C | ounty | | 10c. Ci | ity, Town or L | ocation | | | | | | | | 10d. Inside C | City Limits |
| | Mar. | to | Maryland M | ontgom | ery | Ì | Rock | ville | | | | | | | : | 1 🗆 Yes | s 3 No |
| | th the | by Funeral Olrector | 10e. Street and Number | | | | | 10f. Z | ip Code | | | | 10g. C | Citizen of W | hat Cou | ntry? | - |
| | 15 wi | alC | 14504 Manor P | ark Dr | ive | | | | | 20853 | 3 | | | USA | | | |
| | ems fm | ner | 11. Marital Status | | 12. Was Decede | | J.S. 13. | Was Dec | edent of H | ispanic Ori | gin? (Spe | ecify Yes or No Rican, etc.) | 0- | 14. Race | | can Indian, | |
| 98 | or it | F. | 1 Never Married 2X | | 1X Yes 2 | □No | | 1 Yes | | Specify: | 1, 1 401101 | riicari, etc.) | | | , White, | etc. | |
| 21215-0036 | d within 72 hours after death with the Maryland Jone. I then "naturel", or Items 23a or 28a-f show The Mudical Examination invitiled at | d b | 3 Widowed 4 Div | | Year or Date | s: 1 943 – | 45 | | 243110 | ороспу. | | | | Specify: | Whit | ce | |
| 7 | "nat | lete | 15. Dec (Specify only) | edent's Ed nighest gra | lucation de completed) | | 16a. Dece | kind of w | ork done o | durina mosi | t of workir | ng | 16b. | Kind of Bus | iness/Ir | ndustry | |
| 12 | within ene. then " | Completed | Elementary/Secondary (0 | -12) | College (1-4 | or 5+) | 1 | Dentis | use retired | , | | | | D | | | |
| 9 | be filed stal Hygi of other event, | | 17. Father's Name (First, Mi | ddle. Last) | | | L | encis | L | 18 Mothe | r's Name | (First, Middle | Majda | | istry | 7 | |
| an | \$ 5 5 5 | To Be | Joseph Garret | | | | | | | | | erine Bo | | | ') | | |
| <u>-</u> | d 2 should th and Mer 7 is marke traumatic | ř | 19a. Informant's Name/Rela | | | | 19h Maili | na Addres | c (Street | | | I Route Numb | | | N- 4- 7'- | - 0- 1-) | |
| Maryland | and 2 : ealth ar n 27 is | | | 122 | ,, , | | | | | | | | | | | Code) | |
| ē, | He He | | Allyn Locke Re 20a. Method of Disposition | LILY/ | wite | 20b. I | Place of Dispo | sition (Na | ime of | | | ville, M | - | and 201 Location - 0 | | own State | |
| 9 | | | 1 🔀 Burial 2 □ Crema 4 □ Donation 5 □ Oth | | | ate (| cemetery, cre | matory or | other place | θ) N | lovem | ber 14 | | | , | , | |
| altimore, | 교육관금 . | | 21. Signature of Funeral Se | | | Gat | e of Hea | ven C | emeter | y . | 200 | 16 | Sil | ver S | prin | g, Mai | cylan |
| B | perm Depa Impo any i | | | . (| 0 | | F | ranc | is J. | Coll | lins Blud | Funera I, W, S | 1 He | ome In | nc. | MD ' | 20901 |
| | Physician /Medical | | 23a. Part1. Inter the disea: shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) | se, or comp List only | aEnd-S: | tage F | th. Do not en | ter the mo | de of dying | g, such as | | | | | | Approxima Interval Be Onset and Years | ite tween |
| 100 | Examiner | ıer | Sequentially list conditions, if any, leading to immediate | | End-S | as a consectage D | ementi | .a | | | | | | | | Years | |
| | sate be executed physicien and the burial-transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | 1 | Cache | xia, A | norexi | .a | | | | | | | | Years | |
| ó | en ar | | resulting in death) Last | | Due to (or | as a consec | quence of): | | | | | | | | | | |
| 8760, | ite be iysicii iye bu | cal | | | d. Immob | ility | Syndro | me | | | | | | | | | |
| 9 | Tifica ng ph as th | P | | | | | | | | | | | | | | | |
| P.O. Box | that the death certifical bed by the attending phy odetached for use as the | Physician/M | IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 14 | 23c. If yes, outco 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknow | n 2 ∏ Feta tattime of d | al death 3[| ⊒Ectopic p ∃Other (s | pecify) | - | | | | 23d. Date Mont | | - | Year |
| | law requires that the as been signed by th 2 should be detache | by P | Part II. Other significant co | nditions co | ontributing to deat | h but not res | sulting in the u | nderlying | cause give | n in Part I. | | 23e. Did t | obacco | use contrib | oute lo th | ne cause of o | death? |
| ĕ | quire in sig uld b | | Hypertension | , Arı | rhythmia | , Pro | state | Нуре | rtrop | hy, | | 10 | Yes 2 | 2 ∏ No 3 | □ Prob | ably 4 🗍 | Unknown |
| Division of Vital Records, | aw requir is been si 2 should b | Completed | _Hyperlipider | nia | | | | | | | | 24a. Was | an | 24h W | ere auto | nev findinge | available |
| æ | The lay | E O | | | | | | | | | | autop | osy ormed? | de | ath? | psy findings mpletion of c | ause of |
| ta | ilclan: Th certificate rector, pag | 0 | 25. Was case referred to me | dical | | | | | | 00 Bl | of Dooth | | | 0 1 | Yes | 2 No | |
| <u> </u> | | To B | examiner? 1 ☐ Yes 2★ No | | Hospital: | atient 2 | ER/Outpatier | 4 3 D | Othe | | | (Check only only only only only only only only | | 0 (Y Ou | (0) | Accid | |
| ō | E E = | | 27. Manner of Death | | 28a. Date of I (Month, | | 28b. Time o | | 28c. Injury | at | | 8d. Describe I | | | | Livir | |
| Ö | al or Attending Patter death. I Director: After to in by the funeral | atlo | | ending vestigation | | Day Tear) | Injury | м | Work 1 □ Y | ? ′es 2 🗆 N | No | | | | | | -5 |
| <u>×</u> | Atte | 111 | | ouid not be | 28e. Place of | Injury - At h | ome, farm, str | eet, factor | y, office | | 2 | 8f. Location (S | Street a | nd Number | or Rura | I Route Num | Der, |
| Ö | tal or s afte of Dire | Certification; | - C Monnoida | | building, | etc. (Specif | y / | | | | | City or Tov | vn, Stat | te) | | | |
| | To the Hospital or Atten within 24 hours after deat To the Funerel Director; completely filled in by the | edical | 29a. Certifier 1 XCer (Check only 2 Med one) | tifying Phy lical Exam | ysicien: To the be liner: On the basis and manner | s or examina | owledge, death | n occurred vestigation | at the tim | e, date and inion, deat | place, ar h occurre | nd due to the d at the time, | cause(s | s) and mani nd place, an | ner as si | tated. the cause(s | s) |
| | | Σ | 29b. Signature and title of ce | ertifier | 1. | 1 | | 29 | c. License | number | | | 29d. Da | ate signed (| Month. | Dey, Year) | |
| 2 | 041 | | Mille | n. | Keil | U | m | 9 | D 54 | 749 | | | 7. | Tarrami | 20≈ | 9, 200 | 16 |
| 0 | | | 30. Name and address of pe | rson who o | completed cause of | t death (Iten | n 23a) (Type, | Print) | | | | | | | JET. | 2, 200 | ,0 |
| 5 | 5 9 | | Allen Reilly | | | | | | | 1, Fr | eder | ick, Ma | ary] | Land | | | |
| 4 | Sta Registr | | 31. Date filed (Month, Day, 1 | | 106 32 Regi | strar's Signa | ure . | uli | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician FREDERICK SCHAUB 10, 2006 November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 1 x M 2 □ F 70 **Director** 364-34-4783 April 21,1936 Michigan Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 X No Director Maryland | Frederick Mt. Airv 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or ? 14702 Shirley Bohn Road 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Iral", or items 2 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Internant: If tem 27 is marked other than "natural", or iten Important: If tem 27 is marked other than "natural", or iten Important of the Wedical Examilee one. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sales and Marketing Director Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick F. Schaub, Sr. Irene Verhaeghe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carole A. Schaub / Wife 14702 Shirley Bohn Road Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State November 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory 13, 2006 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** End Stoge /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate linder in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď Abrillation with Rapid Ventricular Response 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, certificate has the irector, page 2 s after death | Director: / d in by the f within 24 hours aft

To the Funeral Di

completely filled in

with the Maryland

death

Baltimore, Maryland 21215-0036

State

Medical Certification: To

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier Williams 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 ☐ Could not be

determined

1 🔀 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28c. Injury at Work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

11/10/06

28d. Describe how injury occurred

Williams Frederick hemonal Hospital

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury

(Month, Day Year)

Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | , | Certificate of Death | Reg. No2 | 006 37730 |
|--------------------------------|--|-----------------|--|--|---|--|
| | | | Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Dey | 3. Time of Death |
| | Physici /Medic | | Alice G. Smith | | November 8, | 2006 11:05 AM |
| | Examin | | 4a Fecility Neme (If not institution, give street end number) | 4b. City, Town, or L | ocation of Deeth 4c. Cou | nty of Death |
| | | | Glade Valley | Walkers | ville Fi | ederick |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. lest birth | hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) | Birthplece (State or Foreign Country) |
| - | Director | ū. | 216-22-1776 1 M 220 F 83 | | July 21, 1923 | Maryland |
| | pu ≱ | | 10a. Stete 10b. County 10c. City, Town | or Location | | 10d. Inside City Limits |
| | denyl | ō | Maryland Frederick Wal | lkersville | | 1 ∑ Yes 2 ☐ No |
| | 18 18 18 18 18 18 18 18 18 18 18 18 18 1 | Director | 10e. Street end Number | 10f. Zip Code | 10g. Citizen | of What Country? |
| | permit. Peges 1 and 2 should be filed within 72 hours after death with the Menyland Department of Haalth and Mental Hyglene. Important: If itam 27 is marked other than "natural", or items 23a or 28a-f ehow important: If itam 27 is marked other than "natural", or items 23a or 28a-f ehow hipportant; If itam 27 is marked other than any injury or other traumatic event, the Medical Examinat must be inditted at once. | | 15 Fulton Ave. | 21793 | Unit | ed States |
| | death 2 | Funeral | 11 Marital Status 12. Was Decedent Ever in U,S. | 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto | pecify Yes or No- | Race - American Indien, Black, White, etc. |
| 0 | The state of the s | Ē | Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No | 1 ☐ Yes 2t No Specify: | | |
| 5 | af', o | þ | 3 ☐ Widowed 4 ☐ Divorced | 1 1es 28 140 Specify. | Зре | ocify: White |
| 2 | 72 ho | Be Completed | 15. Decedent's Education 16a. (Specify only highest grade completed) | Decedent's Usual Occupation (Give kind of work done during most of work | | f Business/Industry |
| 7 | thin the | ğ | Elementary/Secondery (0-12) College (1-4or 5+) | life. DO NOT use retired) | | |
| 7 | ygier Ygier ft. | S | 0 | Seamstress | Sew1 | ng Factory |
| n n | tal H | Be | 17. Father's Name (First, Middle, Last) Charles Jerome Smith | Ida | Keen | |
| Baltimore, Maryland 21215-0020 | ould Men marks marks | 2 | | Mailing Address (Street and Number or Ru | | · |
| a N | l 2 sh and ia m | | | | | |
| e, | l and laalti im 27 | | 20b Method of Disposition 20b Place of | Fulton Ave. / Walk | | on - City or Town, State |
| Ö | if its | - 1 | 1 Burial 2 □ Cremation 3 □ Removal from State cemeter | y, crematory or other place) | | |
| Ħ | t. Pe tmen tant: ijury | | | Rocky Hill Cem. | 1/11/06 Woods | sboro, MD |
| ga Ba | Departimpor mpor any tr | | 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility St. | | |
| i. | 40200 | | Kalmon Jeleson | 40 Fulton Ave. / W | | |
| | | | 2)a ant 1 En 3/ he disease, r complications that caused the death. Do r shock, o 1/ ant failure. List only one cause on each line. | not enter the mode of dying, such as cardiac | or respiratory arrest, | Approximate Interval Between Onset and Death |
| | Physician | | Immediate Cause (Final | | | |
| 4 | /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) a. SAN GREAT Due to (or as a condition or co | Leg | | |
| | | 9 | Due to (or as a o osteonyel | consequence out | | 1 |
| | petr Insit | edical Examiner | U. | consequence of): | | |
| , | exec n and iel-tra | Exa | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying | sateral Disease | _ | |
| 68760, | sa be Asicia | cai | Cause (Disease or injury that initiated events | consequence of): | | |
| | rificeta be executed ng physician and es the buriel-transit | Med | resulting in death) Lest | | | |
| Вох | | | d | | | |
| | 0 0 0 | Physician/ | Part II. Other significant conditions contributing to death but not resulting in | the underlying cause given in Part I. | 23b. Dld tobacco use | contribute to the cause of death? |
| P.0. | requiras that tha been signed by th should be datache | Phy | PARLICINSON'S DISEASE | | 1 □ Yes 2/21 | lo 3 Probably 4 Unknown |
| | as the | by | Hypo Auguminemia | | | 24b. Were autopsy findings |
| ord | v require been si | ted | Hupo Augumin EMIA | | 24a. Was an autopsy performed? | available prior to completion of cause |
| ec | 2 s | nple | | | 10000 | of death? |
| = | | Completed | | | 1 Yes 2 N | 1 ☐ Yes 2 ☐ No |
| of Vital Records, | Physician: The this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | _ Other: _/° | th (Check only one) | 1011 10 11 1 |
| of | his di | 2 | 1 Yes 22 No 1 Inpatient 2 EH/OU | tpatient 3 DOA Nursing H | ome 5 Residence 6 28d. Describe how injury of | |
| 2 | Ing F | ton | 1 Natural 5 ☐ Pending (Month, Day Year) | njury Work? M 1 ☐ Yes 2 ☐ No | | |
| isi | Attending ir death. ector: After by the fune | fica | 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, fa | rm, street, factory, office | 28f. Location (Street and N | umber or Rural Route Number, |
| Division | ii or Attending P s ettar death. I Director: After t d in by tha funer: | Certification: | 4 Homicide building, etc. (Specify) | | City or Town, State) | |
| | To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by tha funer | a C | 29a. Certifier Certifying Physician: To the best of my knowledge | , death occurred at the time, date and place | , and due to the cause(s) an | d manner as stated. |
| | Ho Ho Fu | edical | (Check only one) 2 Medical Examiner: On the basis of examination en and manner stated. | d/or investigation, in my opinion, death occu | rred at the time, date and pie | ice, and due to the cadse(s) |
| | To the To the Comp | Ž | 29b. Signature end fittle of certifier | 29c. License number | 201 | igned (Month, Dey, Year) |
| | | | g/asay | 040307 | MD II | -9-06 |
| | 3 | | 30. Name end eddress of person who completed cause of death (Item 23a) | | | |
| | | | Eugene & Sagrande / 1564 Opossumt | own Pike/ Frederick, | Maryland 21 | 702 |
| | | ate | 31. Date filed (Month, Day, Year) 3 2006 32. Fisher's Signeture | Sparle | | |
| - 3 | Regist | Tai | | | | |

State of Maryland / Department of Health and Mental Hygiene 0 0 6 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) November 7, 2006 **Physician** 11:20 AM **JAMES** R. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery 104 Spring Street Gaithersburg If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□F 093-32-9659 Yrs. Jan. 23, 1941 New York 65 Director Usual Residence of Decedent t0d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural; or Items 23a or 28e-f show any Injury or other traumatic event, the Madical Examinational to once. 10a. State 10b. County 1 X Yes 2 No Md. Montgomery Gaithersburg Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 104 Spring Street United States Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Program Manager Lockheed Martin 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frederick Roy Shay Berthe Lessard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 104 Spring Street Gaithersburg, Md. 20877 Mary J. Shay (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov. 11, Alexandria, Va. Metropolitan Crem. 2006 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licer 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASC Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-translt Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 2 Fetal death 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate To the Hospital or Attending Physician: within 24 hours after death.
o the Funersi Director: After this certific cumpletely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner r 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 110 Nov -mome D 704 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2101 Medical Park Drive #304 Silver Spring, Md. 20902 Dr. Ira N. Brecher M.D. 32 Jegistrar's Signature 31. Date filed (Month, Day, Year) State 09

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Day **Physician** Margaret Ann Savoca 2:50 a M November 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Althea Woodland Nursing Home Montgomery

9. Birthplace (State or Foreign Country) Silver If Under 1 Year 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 ☐ F Director May 16, 1941 Washington, DC 213-38-4249 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Hem 27 Is marked other than "natural" ~ " any injury or other traumatic event." 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3308 Camden Street 20902 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 24 If Yes, Give Year or Dates: 1 ☐ Never Married 2 3 Married 2% No 1 ☐ Yes 2√☐ No Specify Specify:White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Figliozzi Anna Lippincott ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3308 Camden Street, Wheaton, MD 20902 Patrick Savoca, Sr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State November 10, Gate of Heaven Cemetery 4 Donation 5 Dother (Specify) 2006 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis Address Corivins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Aspiration Pnuemonia 1 Week /Medical Due to (or as a consequence of): Examiner Recurrent Seizure Disorder 2 Weeks Sequentially list conditions, Due to (or as a consequence of) Examiner if any beading to immedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Huntington Chorea 15 Years and use as the burial-trai Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by igne be (1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed' 2 X No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 🗆 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer s after dea. ral Director: After 1 X Natural (Month, Day Year) Injury 5 Pending investigation М 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by determined 4 Homicide Hospital To the Hospital within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and little of certifie 29d. Date signed (Month, Day, Year) D21900 November 7, 2006

Registrar

State

Smith S.

31. Date filed (Month, Day, Year)

NOV 0 9 2006

32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ho, M.D.



7610 Carroll Avenue, #280, Takoma Park, MD 20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year p^{M} Joan Ann Stryker November 05, 2006 2:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13610 Montvale Drive Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year Nov. 30, 1 9. Birthplace (State or Foreign Country) New Jersey 1 ☐ M 2 🖾 F 149-26-1289 71 1934 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13610 Montvale Drive 20904 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Caucasian Specify: δ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress 12 Deli 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George William Hulseart Elise Lillian Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Stitt / Daughter 529 Monmouth Road, Jackson, New Jersey, 08527 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IN Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 11/09/2006 Brentwood, Maryland 21. Signature of Funeral Service Croensee Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 Approximate Interval Between Onset and Death

Physician /Medical Examiner

permit. Page Department o important: if any injury or once.

Funeral

, or itams 23s or 28e-f show

'natural'

the Medical Examiner must be notified at

with the Maryland

deeth

filed within 72 hours after

Pages 1 and 2 should be filed nent of Heelth and Mental Hygi Int: If item 27 is marked other

Baltimore, Maryland 21215-0036

Examine igned by the attending physicien be detached for use as the buria

The law requires that the death certificate be executed

hes

this certificete

To the Hospital or Attanding Physician:

3

death.

within 24 hours a To the Funeral I

Joan A. Shry her. Division of Vital Records, P.O. Box 68760,

Physician/Medical Be Completed by Director: After this certific in by the funeral director, Certification: To Medicai

| J | COX Jo. 4 | | | | 040 | KOCKV1 | rie Like | , KOCKVI. | ııe, |
|---|--|-----------------------|---|-------------|------------|----------------|-------------------|---------------------|------|
| | 23a. Part1 Enter the disease, or shock, or heart failure. List of | omplicat nly one o | ons that caused the death ause on each line. | n. Do not e | nter the r | node of dying, | such as cardiac o | r respiratory arres | it, |
| | Immediate Cause (Final disease or condition resulting in death) | _ a | Metastatic | Carci | noma | of the | vulva | | |
| l | resulting in death) | | Due to (or as a consequent | uence of): | | | | | |
| | Sequentially list conditions, If any, leading to immediate | b | Due to (or as a nonsequ | ranca of): | | | | | |
| | cause. Enter Underlying Cause (Disease or injury that initiated events | C | | | | | | | |
| | resulting in death) Last | | Due to (or as a consequ | uence of): | | | | | |
| | | d | | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant | 23c. | If yes, outcome of pregna 1□Live birth 2□Fetal | | □Ectopi | c pregnancy | | | 23d |

4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☒ No 9 Unknown

Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 ☐ Probably 4 ☑Unknown

24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔯 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA

Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

11/08/2006

D0055522 death (Item 23a) (Type, Print)

Robert H. Gerard, M.D.

1500 Forest Glenn Road, Silver Spring, MD 20910

State Registrar

31. Date filed (Month, Day, Year) NOV 13 2006



State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** MARGARET SCHOPMEYER NOVEMBER 7, 2006 10:45P M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 11212 VALLEY VIEW AVENUE KENSINGTON MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** WASHINGTON, DC 213-50-7298 1 ☐ M 2 🖾 F 96 Yrs. JAN. 19, 1910 Director Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland ment of Heelih and Mental Hygiene.
ent: if item 27 is marked other then "naturel", or iteme 23s or 28s-f ehow ury or other than the month item and item 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 🖔 No SILVER SPRING Director MARYLAND MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES OF AMERICA 20903 2024 FOREST HILL DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🗵 No Specify: Specify: Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PHYSICAL THERAPIST MEDICINE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HELEN LOUISE JOHNSON EDWARD EDGECOMBE CARTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11212 VALLEY VIEW AVENUE, KENSINGTON, MARYLAND 20895 CRAIG SCHOPMEYER - SON 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of H importent: If ite any injury or of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State FT. LINCOLN CREMATORY 11/22/06 BRENTWOOD, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Sign than of Funeral Service License 22. Name and Address of Facility HINES - RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE, SILVER SPRING, MD 20904 Approximate Interval Between Onset and Death 23a. Part Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 30 YEARS **Physician** CHRONIC OBSTRUCTIVE PULMONARY DISEASE resulting in death) /Medical Due to (or as a consequence of): Examiner S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine S The law requires that the death certificate be executed the attending physicien and hed for use as the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a of be detached for P.O. 1 ☐ Yes 2 🖾 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes pege 2 autopsy performed? certificete 1 Yes 2 No 1 Yes 2 XNo of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Division 5 Pending 1 ANatural 1 ☐ Yes 2 ☐ No i Director: A М investigation 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitei o within 24 hours eff To the Funerei Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of bertifier 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 9, 2006 D0031563 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10801 LOCKWOOD DRIVE #205 SILVER SPRING, MD 20901 CHARLES M. BENNER, MD 31. Date filed (Month, Day, Year) NOV 1 3 32 Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registra MEND#16a/boerFH11/22/06, BW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Month **Physician** Year 20:29 M DANIELLE NOVEMBER 6, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 4.5-1974 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F Maryland Director 219-82-9781 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or iteme 23s or 28s-f show the Medical Exeminer must be notified at Director 1X Yes 2 No Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 U.S.A. 9010 Elmonte Woods Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
illa DO NOT use refrect)
Health Claims Assistant
Rever worked 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Insurance di Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Sacks Andrea Elias 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an item 27 is 9010 Elmonte Woods Way Ellicot City, MD 21042 Robert D. Sacks- Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
eny injury or ott 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens 11-9-06 Olney, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, MD 20852 Do 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ACUTE RENAL FAILURE Physician 5 DAYS resulting in death) /Medical Due to (or as a consequence of): **Examiner** SEPSIS NESICS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MULTIPLE USOPLASMS WITH BRAIN 1 Yes 2 No 3 Probably 4 Unknown UL METASTIASES -24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an FANCONI'S ANEMIA 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ∰Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

P.O. Box 68760 Division of Vital Records. lospital or Attending P I hours after death. uneral Director: After to sly filled in by the funeral To the Hospital
within 24 hours a

Baltimore, Maryland 21215-0036

RES-000 NOVEMBER 6, 2006 JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE MA 21707 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILFY Registrar

and manner stated.

29b Signature and title of certifier

29c. License numbe

29d. Date signed (Month, Day, Year)

| | | | Tor State Registrar | State of Ma | aryland / | | irtment of | Health and I Death | | giene2 | 006 | 37736 |
|----------------------------|---|------------------|---|---|------------------|---|--|---|--|---|---|---|
| | Physici /Medic | | 1. Decedent's Name (First, Middle, Last) | L | S | 41 | 77 | | 2. Date of De. Month | | 2006 | 3. Time of Death 2/09 M |
| is . | Examin | er | 4a. Facility Name (If not institution, give si Anne Arundel Medi | cal Cente | | | | or Location of Death | 5 | | | undel |
| | Funeral Director | | 5. Social Security Number 216-22-2692 1 Usual Residence of Decedent | M 200-F 7. Ag | 77 | Yrs. | If Under 1 Yea Months Day | | 8. Date of Bird (Month, Da Nov. 2 | y, Year) 2, 192 | 9. Birth Cou Ma | place (State or Foreign intry) aryland |
| | Maryland -f show | tor | 10a. State 10b. County Maryland Anne Aru | ndel | 10c. City, To | own or Lo | | nnapolis | | | | 10d. Inside City Limits 10d. Yes 2 □ No |
| | a or 28e | i Director | 10e. Street and Number 138 Conley Drive | | | | 10f. Zip Code | 21403 | | 10g. Citizen | of What Cou | |
| 20 | tiled within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23a or 28a-f show ther then "natural", or items 23a or 28a-f show ent, the Madical Examined and | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ᡚ Divorced | 2. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates: | | 1 | Vas Decedent of Yes, specify Cu | Hispanic Origin? (S ban, Mexican, Puert o <i>Specify:</i> | pecify Yes or No o Rican, etc.) | | Race - Ameri Black, White Icify: Wh | |
| 0500-6121 | d 2 should be filed within 72 hours th and Mental Hygiene. 7 Is marked other than "natural", treumatic event, the Medical Ex | Completed | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) | | | (Give | lent's Usual Occ kind of work don DO NOT use reti | e during most of wor red) | | | of Fd1 | nduslry acation |
| Maryland 21 | ₽ E P S | To Be Co | 12 17. Father's Name (First, Middle, Last) Edgar E. Caldwell | | | | re15011 | 18. Mother's Nar | ne (First, Middle, y A. Wil | Maiden Surr | | |
| Baltimore, Mary | permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 is marke any Injury or other treumatic <u>once</u> . | | 19a. Informant's Name/Relationship (Typ. Jeffrey Suitt/son 20a. Method of Disposition 1☆ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sentice License | emoval from State | 20b. Place | 5475 of Dispo of Disp | Oaklane sition (Name of natory or other p w the F . Name and Add | isherman (Iress of Facility Jol | oldsboro Date 11/11/20 nn M. Ta | , Mary 20c. Location 06 ylor F | land on-City or T Mayo, uneral | 21636 own, Slate Maryland |
| 68760, | The law requires that the death certificate be executed The law requires that the death certificate be executed The law required to the attending physicien and in property of the print | dical Examiner | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as | a consequent | ce of): | er the mode of d | ying, such as cardiac | c or respiratory a | rrest. | | Approximate Interval Between Onset and Death |
| F.C. BOX | that the death certific ed by the attending p detached for use as | Physician/Me | 1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown | 2 Fetal dea | ath 3□ | Ectopic pregnar Other (specify) | | | | Date of delin Month | very Day Year |
| | w requires that been signed by should be deta | 5 | Part II. Other significant conditions con | tributing to death b | oul not resultin | g in the u | nderlying cause | given in Part I. | 23e. Did t | _ | | the cause of death? |
| al Reco | : The law recate has bee | Completed | V | | | | | | 24a. Was auto perfo 1 \(\text{Yes} | an 24 psy prmed2 2 D No | b. Were aut prior to c death? 1 Yes | opsy findings available ompletion of cause of |
| Division of Vital Records, | utending Physician: The death. ctor: After this certificate his y the funeral director, page | ation: To Be | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | ospital: (1) Patie 28a. Date of Inju (Month, Da | | Outpatier b. Time of | f 28c. In | Other: 4 Nursing F | ath (Check only of Home 5 Resi 28d. Describe | dence 6 - | curred | |
| DIVIS | the Hospital or Attending in 24 hours after death. the Funeral Director: After apletely filled in by the fune | I Certification: | 3 Suicide 6 Could not be determined | | tc. (Specify) | | | | City or To | wn, State) | | ral Route Number, |
| | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer | Medical | 29a. Certifier (Check only 2 Medical Examinone) 29b. Signature and title of certifier | | f examination | | vestigation, in m | y opinion, death occ | urred at the time, | date and pla- 29d. Date sie | ce, and due | to the cause(s) |
| | 5 | | 30. Name and address of person who co | mpleted cause of a | death (Item 23 | а) (Туре. - Ч 1 | Prior | WSE HIG | + thur Ay | ANN | APOLO | 7,206 Mo21401 |
| | St Regist | ate | 31. Date filed (Month, Day, Year) | | rar's Signature | 1 | and) | | | | | |

| | | | For State Registrar | | State of | Marylar | • | artment <i>tificate</i> | | | and M | lental Hy | giene | 006 | 37737 |
|----------------------------|---|----------------|--|-------------------------------------|---------------------------------------|----------------------------------|---|--------------------------------------|-------------------------------|--------------------|-----------------------|---|---------------------|------------------------------|--|
| | Physici | 90 | 1. Decedent's Name (First Felice Roo | | | V | 4-1-1-1 | | | | | 2. Date of Dea Month NOV. | | 2006 | 3. Time of Death 9:30 a M |
| | /Medic Examin | _ | 4a. Facility Name (If not in 511 Bayber | stitution, give s | treet and numi | ber) | | 4b. City, To | | Location o | | 1.0 4 | 4c. Co | ounty of Dea | |
| - 34 | Funeral Director | | 5. Social Security Number 212-30-0178 | 6. Sex | | . Age (In yrs. 96 | last birthday) Yrs. | If Under 1 Months | Year Days | If Under: Hours | 24 Hrs. Min. | 8. Date of Birt (Month, Da Dec. 2 | h Year 19 | 9. Bin | thplace (State or Foreign ountry) MN |
| | Aaryland ed at | or | | dent County Ine Aru | ndel | 10c. Ci | ty, Town or Lo | | erna | a Par | k | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| | or 28a- | Director | 10e. Street and Number | | | | | 10f. Zip C | Code | | | | 10g. Citize | n of What Co | ountry? |
| | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Department of Heatil and Mental Hygiene. Bright of them 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once. | by Funeral I | 511 Bayber 11. Marital Status 1 Never Married 2 | | VE 12. Was Deced Armed Ford 1 □ Yes 2 | es? | J.S. 13. \ | Was Decede f Yes, specif | 211 ent of His by Cuban | | gin? (Spe , Puerto | ecify Yes or No- Rican, etc.) | - 14 | | SA erican Indian, te, etc. |
| 21215-0036 | 2 hours af atural', or cal Exam | | 3 ∑ Widowed 4 □D | ivorced ecedent's Edu | If Yes, Give Year or Dat | | 16a. Deced | 1 ☐ Yes 2 | Occupat | Specify: | (| | | oecify: of Business | White |
| 2121 | ed within 7 rgiene. er then "n t, the wed | Completed | Elementary/Secondary | | College (1- | for 5+) | life. I | kind of work DO NOT use Homema | ker | | | | | Ної | ne |
| Maryland | ould be fill Mental Hy parked oth | To Be | 17. Father's Name (First, and Burt Presto | n Root | | | | | | Faye | Bab | e (First, Middle, pette de | Lafay | ette | |
| , Mar | and 2 shealth and 27 is m | | 19a. Informant's Name/Re Emily McGea | | | | | old C | | | | Severn | | | |
| Baltimore, | Pages 1 and of He not: If Item ary or oth | | 20a. Method of Disposition 1 □ Burial 2 ▼ Crer 4 □ Donation 5 □ C | nation 3 🗆 A | emoval from S | ate | Place of Dispo cemetery, crem etro Cr | natory or oth | er place, | ľ | Nov. | 11, 06 | | tion · City or imore, | |
| Balt | permit. Departr Imports any inj | | 21. Signal e Frieral S | Service License | 7/ | | Ba | Name and arranc 95 Gov | 0 & | Sons | , P. | A. Sev | erna erna | Park I Park, | Funeral Home MD 21146 |
| h | Physician | | 23a. Part1. Enter the disc shock, or heart failur Immediate Cause (Final disease or condition | ease, or compli re. List only or | ne cause on ea | used the dea ch line. Voke | | er the mode | of dying, | , such as | cardiac d | or respiratory ar | rest, | | Approximate Interval Between Onset and Death ### AAYS |
| | /Medical Examiner | | resulting in death) Sequentially list condition | . (| | r as a consec | quence of): | | | | | | | | |
| 8760, | rate be executed hysician and the burial-transit | Ilcal Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | r as a conse | | | | | | | | | |
| P.O. Box 6 | ath certific titending p or use as | Physician/Med | IF FEMALE: 23b. Was decedent pregr in the past 12 menth 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | iant | | th 2 ∏ Feta ntattime of o | aldeath 3□ | Ectopic pred Other (spec | | | | | 230 | d. Date of de Month | livery Day Year |
| rds, P | w requires that the de been signed by the a should be detached f | рy | Part II. Other significant of | conditions cor | tributing to dea | th but not res | sulting in the u | nderlying cau | use giver | n in Part I. | | | bacco use es 2 🗂 | | o the cause of death? |
| Division of Vital Records, | sicien: The law re certificate has ber irector, page 2 sho | Completed | | | | | | | | | | 24a. Was autop perfor | rmed? | 24b. Were au prior to death? | utopsy findings available completion of cause of 2 No |
| Vita Vita | sician: certific | To Be | 25. Was case referred to examiner? 1 ☐ Yes 2 ☐ No | | lospital: | patient 2 |] ER/Outpatien | t 3 🗆 DOA | Othor | ~ | - | n (Check only o | | Other (See | (a) |
| ion of | nding Physicien: The ath. r: After this certificate hate funeral director, page | | 27. Manner of Death | Pending investigation | 28a. Date of (Month | | 28b. Time of Injury | | c. Injury : Work? | | | 28d. Describe h | | | City) |
| Divis | Dir | Certification: | 4 Homicide | Could not be determined | building | g, etc. (Speci | | | | | | City or Tow | m, State) | | ural Route Number. |
| | • Hospitel 24 hours • Funerel letely filled | Medical | 29a. Certifier 1 (♥ C (Check only 2 □ N one) | Certifying Phys ledical Exami | ner: On the bas | is of examin | ation and/or in | restigation, ii | n my opi | nion, deal | th occurr | and due to the d ed at the time, d | date and pl | ace, and due | to the cause(s) |
| _ | To the within 2 To the comple | M | 29b. Signature and title of | 11 . | Nulle | is As | 10 | 29c. | License 57 | number | 7 | | 29d. Date s | igned (Mont | th, Day, Year) 7 2006 |
| | .0 | | 30. Name and address of | person who co | mpleted cause | of death (Ite | m 23a) (Type, | Print) | h | | | la A | N/ac 4 | / · · /- | 1214 |
| | ال Sta Registi | | 31. Date filed (Month, Da) | Miller V 082 | 14 D 106 32.6 | gistrar's Sign | atura | and well | w | 9 5 | nitt | (10 1/1 | - In | · /^ | n, Day, Year) 7 2006 (1) 21401 |

| | | | 1 - For State Registrer | State of M | larylan | | artmen <i>rtificat</i> | | | and M | lental Hy | giene Reg. No | 2006 | 37738 |
|-------------|---|----------------|---|--|---------------------------------|---|---|--------------------------|---------------------------------------|-----------------------|--|------------------------|---|---|
| | Physic /Medi | cal | Decedent's Name (First, Middle, Las WILLIAM SUMMERS 4a. Facility Name (If not institution, give | , | · | | 4b Cib | Tour or | Location o | f Dooth | 2. Date of De Month NOVEMB | ER C | y Year 17 17 17 17 17 17 17 17 17 17 17 17 17 | 3. Time of Death 8:24A |
| | Examir Funeral | ner | 8501 KEEBLER DRI 5. Social Security Number 6. Se | VE x 7. A | , | ast birthday) | C If Under | LINT 1 Year | ON If Under 2 | 24 Hrs. | 8. Date of Bir | th | PRINCE O | GEORGES |
| | Director | | 245 58 9387 Usual Residence of Decedent 10a, State 10b, County | ₹M 2□F | 64 | Yrs. | Months | Days | Hours | Min. | (Month, Da APR. 2 | 3, 1 | 942 NORT | TH CAROLINA |
| | ath with the Marylan s 23a or 28a-f show | Director | MD PRINCE O | EORGES | | INTON | 10f. Zip | Code | | | | 10g. Ci | tizen of What Cou | XXYes 2 □ No |
| 980 | ours after de ai', or Itams Exacilher | by Funeral | 8501 KEEBLER DRI 11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced | VE 12. Was Deceden Armed Forces XIXYes 2 ITYES, Give Year or Dates: | ?] No | 1 | Vas Decec | offy Cuba | spanic Orig n, Mexican Specify: | gin? (Spo , Puerto | ecify Yes or No Rican, etc.) | - | IITED STA 14. Race - Ameri Black, White, Specify: BLA | ican Indian, , etc. |
| 21215-0036 | d within giene. r than | Completed | 15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12TH | ucation le completed) College (1-4or | 5+) | life. L | lent's Usua kind of woi DO NOT us SING | rk done d se retired, | uring most | | ing | | GOVERNM | , |
| Maryland | should be filed vind Mental Hygies marked other tumatic evant, In | To Be C | 17. Father's Name (First, Middle, Last) WILLIAM SUMMERS | | | | | | EL | IZAE | First, Middle | , Maider OMPS | o Sumame) | |
| | 1 and 2 Health a am 27 is | | 19a. Informant's Name/Relationship (T. SHETLA WARD-SUMM) 20a. Method of Disposition | ERS / WI | 20b. PI | | KEEB | LER | DRIVE | | | ON, | or Town, State, Z_{ij} $ \begin{array}{ccc} \text{MD} & 20735 \\ \text{ocation - City or T} \end{array} $ | |
| Baltimore, | permit. Pages Department of Important: if it any injury or o | | XX Burial 2 Cremation 3 1 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licenses) | | 9 | YLAND Y | VETER | ANS | CEM. | | 6/2006 HOME | | HELTENHA ARYLAND, | |
| | Physician | | 23a. Part1. Enter the disease, or comp shock/or heart failure. List only of Immediate Cause (Final disease or condition | lications that cause ne cause on each | line. | n. Do not ente | 4308 er the mod | SUIT e of dying | LAND , such as o | ROAI cardiac c | SUITL. | AND, | MD 2074 | |
| 8760, | /Medical Examiner ohysician and the burial-transit | dicai Examiner | resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or a. Du | s a consequ s a consequ | uence of): | | | | | | | | 3 THATE |
| .O. Box 6 | ne death certific the attending p thed for use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown | 2 Fetal | death 3 | Ectopic pro | | | | | and the second | 23d. Date of delive Month | ery Day Year |
| S, P | ires that signed b d be deta | by | Part II. Other significant conditions co | ntributing to death | but not resu | ilting in the ur | derlying ca | use give | n in Part I. | | | obacco (| _ | he cause of death? |
| I Record | The law ate has b page 2 sl | Completed | | | | | | | | | 24a. Was autop perfo 1 Yes | | prior to co death? | opsy findings available impletion of cause of |
| on of Vital | Attending Physician: 1 r death. actor: After this certifical by the funeral director, p | ition: To Be | 25. Was case referred to medical examiner? XXYes 2 No 27. Manner of Death XXNatural 5 Pending investigation | Hospital: 1 ☐ Inpati 28a. Date of Inj (Month, Da | ury | ER/Outpatient 28b. Time of Injury | | Bc. Injury Work | 4 Nur | sing Hor | (Check only one XX Residence Residence of the control of the contr | dence | 6 | (y) |
| Division | of after in l | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of In building, e | njury - At hor tc. (Specify) | me, farm, stre | eet, factory | office | | 2 | 28f. Location (S City or Tov | Street an vn, State | nd Number or Rura | ai Route Number, |
| | To the Hospital within 24 hours a To the Funerel I completely filled | Medical | 29a. Certifier (Check only one) 2 Madical Exami | sician: To the best ner: On the basis of and manner s | or examinati | vledge, death ion and/or inv | estigation, | in my op | nion, deati | l place, a | and due to the ed at the time, | cause(s) date and | and manner as s d place, and due to | tated. o the cause(s) |
|) | To To com | 2 | 29b. Signature and little of dertifier | 66 | U | |] | License | | | | 29d. Dai | te signed (Month, $10/0$ | Day, Year) |
| | Sta Registr | | B. REDJAEE, M.D. 31. Date filed (Month, Day, Year) NOV 13 2006 | | 4467 | 23a) (Type, F | BRANCI | H AV | ENUE | TE | MPLE HI | LLS | , MD 207 | 48 |

| | | | 1 - For State Registrar | State of Marylar | nd / Depa | artment of H | ealth and N | | giene 2006 | 37739 |
|------------|---|------------------|--|---|------------------------|---|--------------------------------|--|--------------------------------------|---|
| | Physici | an | 1. Decedent's Name (First, Middle, Las William E. | | | | | 2. Date of Dea Month | nth Day Yeer | 3. Time of Death |
| | /Medic Examin | | 4a. Facility Name (If not institution, give | | | 4b. City, Town, or | Location of Death | Nov. | 10 2006 4c. County of Dea | 6:05A M |
| | - Zarriii | C1 | 7635 Esham Rd. | | | | onsburg | | Wicomic | 0 |
| | Funeral Director | | 5. Social Security Number 6. S 290-12-9222 1 Usual Residence of Decedent | ex 7. Age (In yrs. 88 | last birthday) Yrs. | It Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day Sept. | 7. Year) 9. Bii C 1, 1918 W | thplace (State or Foreign ountry) |
| | ylend wow | | 10a. State 10b. County | 10c. Cit | ty, Town or Lo | ocation | | | | 10d. Inside City Limits |
| | e Mar | ctor | MD Wicomic | o Pa | rsonst | ourg | | | | 1 ☐ Yes 2 🔀 No |
| | with th | Funeral Director | 10e. Street and Number 7635 Esham Rd. | | | 10f. Zip Code | | | 10g. Citizen of What C | ountry? |
| | ns 23 | erai | 11. Marital Status | 12. Was Decedent Ever in U | .S. 13. | 21849 Was Decedent of Hi | spanic Origin? (Sc | ecify Yes or No- | USA 14. Race - Am | erican Indian. |
| 0500-0 | be filed within 72 hours after death with the Marylend at Hygiene. An Hygiene dither than "natural", or items 23a or 28a-f ahow avant, the Medical Examinar must be notified at | þ | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: | | Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No | n, Mexican, Puerto Specify: | Rican, etc.) | Black, Whi | te, etc. |
| <u>.</u> | "natu | Completed | 15. Decedent's Ed (Specify only highest gra | ducation de completed) | 16a. Dece (Give | dent's Usual Occupa kind of work done of DO NOT use retired | ation furing most of work | king | 16b. Kind of Business | /industry |
| 7 7 | within lene. then | dwc | Elementary/Secondary (0-12) | College (1-4or 5+) | | ick Driver | | | Food Comp | nanv |
| 20 | | Ö | 17. Father's Name (First, Middle, Last) | | 110 | ick bilver | | e (First, Middle, | Maiden Sumame) | , any |
| yland | 2 should be a and Mental is marked o | To Be | Raleigh William | Sadler | | | Betty V | arney | | |
| Mar | s 1 and 2 should 1 Health and Mer Item 27 is marke other traumatic | | 19a. Informant's Name/Relationship (| | | | | | r, City or Town, State, | Zip Code) |
| | 1 and Healt Iem 2 | | John Sadler (nep | | /035 Place of Dispo | ESNAM Rd sition (Name of matory or other place | ., Parso | nsburg, | Md. 21849 20c. Location - City of | Town, State |
| Ē | Pages nent of int: if its iry or o | | 1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ | | | matory or other place llopen Cre | | 11-2006 | Frankford, | |
| saitimore, | permit. Pages Depertment of I important: if its any injury or or once. | | 21. Signature of Funeral Service Licer | | 2: | 2. Name and Addres | s of Facility Th | e Burbaç | ge Funeral | Home |
| <u> </u> | 80.5 2 3 | | feett | nell | | 08 Willia | | · · · · · · · · · · · · · · · · · · · | | |
| | Physician /Medical | | Part1. Enter the disease, or com shock, or heart failure. List only tmmediate Cause (Finat disease or condition resulting in death) | a | | ASCVI | g, such as cardiac | or respiratory an | rest, | Approximate Interval Between Onserand Death |
| | Examiner | | Sequentially list conditions. | b | | | | | | |
| 7 | ted nsit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consec | ruence of): | | | | | |
| <u>,</u> | execu in and iai-tra | Exar | that initiated events resulting in death) Last | C. Due to (or as a consec | juence of): | | | | | |
| 6876U, | ficate be executed physicien and is the burial-transit | ical | | d | | | | | | |
| O. Box | at the death certificate be executed by the ettending physicien and tached for use as the burlat-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | 23c. If yes, outcome of pregnant Live birth 2 Feta 4 Pregnant at time of conditions Unknown | Il death 3 | □Ectopic pregnancy □ Other (specify) | _ | | 23d. Date of de Month | livery Day Year |
| λ, J | requires that the leen signed by th hould be detache | by Ph | Part II. Dther significant conditions of | ontributing to death but not res | ulting in the u | inderlying cause give | en in Part I. | 23e. Did to | bacco use contribute t | o the cause of death? |
| cords | w require been sig should b | ted k | | | | | | 1 🗆 Y | es 2⊡No 3⊡P | robably 4 Unknown |
| a) | | Completed | | | | | | 24a. Was a autop | sy prior to | utopsy findings available completion of cause of |
| E E | sicien: The law certificate has l irector, page 2 s | | 25. Was case referred to medical | | | | | perfor 1 ☐ Yes | 2 No 1 □ Yes | s 2□ No |
| VItal | Physician: r this certifica ral director, p | To Be | examiner? 1 Pres 2 No | Hospital: 1 ☐ Inpatient 2 ☐ | FB/Outpatie | nt 3 DOA Othe | 26. Place of Deal | | ne) ence 6 □Other(Spe | Market |
| 0 | B 5 5 | | 27. Manner of Death 1 Naturat 5 Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time o | t 28c. Injury Work | at | 28d. Describe h | ow injury occurred | спу |
| <u> </u> | Attending it death. actor: After by the fune | catic | 2 Accident investigation 3 Suicide 6 Could not b | 1 | | M 1 🗆 1 | res 2 □ No | | | |
| DIVISION | F 8 F C | Certification: | 4 Homicide determined | building, etc. (Special | | | | City or Tow | | |
| | To the Hospital of within 24 hours at To the Funeral D completely filled in | Medicai | (Check only 2 Medical Exar | nysician: To the best of my kno niner: On the basis of examina and manner stated. | ation and/or in | vestigation, in my op | pinion, death occur | red at the time, o | ate and place, and du | s stated. e to the cause(s) |
| | To the within 2 To the complet | Σ | 29b. Signature and title of cartitier | | | 29c. License | number | i | 29d. Date signed (Mon | th, Day, Year) |
| | | | 30. Name and address of person who | completed cause at death the | n 22a) /T | Print) | (۲۲۷ | | 11/10/06 | |
| В | A 4 | | 30. Name and address of person who | 100 ECAVION | (Type, | 29c. License HSC Salisbe | my mo | 2180 | 0) | |
| | Sta | ite | 31. Date tiled (Month, Day, Year) | 32. Regitrar's Signa | ature | back 1 | | | | |

| | | Flease | Type of Print in | | | • | • | |
|--|----------------|--|---|------------------------------------|---|---------------------------|---------------------------------------|---|
| | | . For | State of Maryla | and / Departme | ent of Health and | Mental Hygie | | 0 1 1 |
| | | 1 - State Registrar | | Certifica | ate of Death | Reg. | N2 UU6 | 3//4/ |
| | | 1. Decedent's Name (First, Middle, La | st) | | | 2. Date of Death | | 3. Time of Death |
| Physic | ian | | A ARRESTON IN | | | | Day Year | 11:59 AM |
| /Medi | cal | | MAS, JR. | | | | 06 2001 | |
| Exami | ner | 4a. Facility Name (If not institution, giv | | 10 - 1 | ity, Town, or Location of Dea | | 4c. County of Dear | n |
| | | 0. | LARYLAND MEDIC | | BALLIMO | - | | |
| Funeral | | 5. Social Security Number 6. S | | Month | der 1 Year If Under 24 Hr ns Days Hours Mir | | ar) 9. Birt | hplace (State or Foreign |
| Director | | 415.44.2676 | 124 2□F 74 | Yrs. | | | 1932 Ter | nnessee |
| 9 | | Usual Residence of Decedent | | | | | | |
| ylar | | 10a. State 10b. County | 10c. | City, Town or Location | | | | 10d. Inside City Limits |
| Mag | ģ | Maryland Montgom | ery | Silver Spri | ing | | | 1 ☐ Yes 2 🔀 No |
| 288 7 | Director | 10e. Street and Number | | 10f. | Zip Code | 10g. | Citizen of What Co | ountry? |
| with so | 0 | 13116 Andrew Dri | *** | | 20904 | 7 | J.S.A. | |
| ILK I 3-0030 within 72 hours after death with the Maryland ene. then "naturat", or items 23e or 28e-f show the Madical Exeminating at | Funeral | 11. Marital Status | 12. Was Decedent Ever in | IIS 13 Was De | | | 14. Race - Ame | ncan Indian |
| er d | Š | | Armed Forces? | , , , | cedent of Hispanic Origin? (specify Cuban, Mexican, Pue | erto Rican, etc.) | Black, Whit | |
| saft saft | by F | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give | to 1 Yes | s 2 No Specify: | | Specify: Wh | nite |
| B hour B | D D | | _ | 960 | | 100 | Kind of B | |
| p 2 ig | ete | 15. Decedent's Ed (Specify only highest gra | aucation ade completed) | 16a. Decedent's U (Give kind of | work done during most of w | orking | . Kind of Business | industry |
| iti e | ם | Elementary/Secondary (0-12) | College (1-4or 5+) | `life. DO NO | | Affairs | Fd., o a t d a m | |
| A Sept a | Completed | | 5+ | Vice-Pr | esident of S | eadelle | Education | L |
| be filed that Hyging of other event, I | Be | 17. Father's Name (First, Middle, Last, |) | | 18. Mother's Na | ame (First, Middle, Maid | den Sumame) | |
| ic e did b | P | William Lee Th | nomas, Sr. | | Earse | l McKinney | | |
| ITE; MISTYISTIC X IX INCUSO s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "naturat", or items 23s or 28s-f show other traumatic event, it a Medical Examination at the notified at | - | 19a. Informant's Name/Relationship (| Type, Print) | 19b. Mailing Addre | ess (Street and Number or F | Rural Route Number, Cit | ty or Town, State, 2 | Zip Code) |
| MG d 2 is | | Betsy W. Thomas/ | Jifa | 13116 An | drew Drive, | Silver Spri | na Marvi | land 2000/ |
| Defittinore, N permit. Pages 1 and Department of Health Important: If Item 27 any njury or other to | | 20a. Method of Disposition | | D. Place of Disposition (/ | | | . Location - City or | |
| P F P | | 1 🗆 Burial 2 🖾 Cremation 3 | Removal from State | cemetery, crematory of | or other place) 11/ | 10/ | . Location only or | TOWN, State |
| DESILLING Permit. Pages Department of mportant: If it is not njury or o | | 4 □ Donation 5 □ Other (Specif | y) Fo | | Crematory 20 | | entwood, | Maryland |
| y point. | | 21. Signature of Funeral Service Lice | see | 22. Name | and Address of Facility -RINALDI FUNE | DAT HOME | TNC | |
| a 8988 | | Noncon A | Yucan \ | ~ 11800 | New Hampshir | e Ave. Silv | ver Sprin | o MD 2090/ |
| | | 23a. Part 1. Enter the di ease, or com | plications that caused the de | | | | DI L | Approximate |
| | | shock, or hea 1 failing. List only Immediate Cause (Final | | 0 - 1 - 1 | . — | | | Interval Between Onset and Death |
| Physician | • | disease or condition resulting in death) | a. CERE | BRAL HER | LNIATION | | | |
| /Medical Examiner | | rooming in sound | Due to (or as a cons | sequence of): | 1/- | | | |
| Lammer | | Sequentially list conditions | b. CEREP | BROVASCUla | R STROKE | | | |
| | Je. | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a cons | sequence of): | | | | |
| utec | Ē | Cause (Disease or injury that initiated events | C | | | | | |
| box oo/fou, death certificate be executed e attending physicien and id for use as the burial-transit | Examiner | resulting in death) Last | Due to (or as a cons | sequence of): | | | | |
| e be ex | cai | | d | | | | | |
| phy: | | | . 0. | | | | | |
| Se as | Physician/Medi | IF FEMALE: | 22c If was outcome of pre | ana nov | | | | |
| ath cer ttendir | an | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F | etal death 3 Ectopic | pregnancy | | 23d. Date of del Month | ivery Day Year |
| des des des des des des des des des des | 2 | 1 ☐ Yes 2 ☐ No | 4☐Pregnant at time of 9☐Unknown | of death 5 ☐ Other | (specify) | | , , , , , , , , , , , , , , , , , , , | Day Tour |
| by the | چ | 9 Unknown | | | | | | |
| stha ned e de | by F | Part If. Other significant conditions | contributing to death but not | resulting in the underlyin | g cause given in Part I. | 23e. Did tobacc | co use contribute to | the cause of death? |
| ulres ulres ld be | | | | | | 1 ☐ Yes | 2 □ No 3 □ Pr | obably 4 Unknown |
| w require | Completed | | | | | 04- 146 | 045 144 | talan Cadlana and Data |
| has has | 뎔 | | | | | 24a. Was an autopsy | prior to | topsy findings available completion of cause of |
| ate pag | Ö | | | | | performed 1 ☐ Yes 2 💆 | | 2□ No |
| in in in in in in in in in in in in in i | Be | 25. Was case relerred to medical | | | 26. Place of D | eath (Check only one) | | |
| VISION OF VITA Attending Physician: or death. ector: After this certific by the funeral director, | 10 | examiner? 1 ☐ Yes 2 ☑ No | Hospital: 1 Inpatient 2 | P.□ ER/Outpatient 3□ | DOA Other: 4 Nursing | Home 5 ☐ Residence | 6 ∏Other (Spe | cifv) |
| Phy or this | | 27. Manner of Death | 28a. Date of Injury (Month, Day Year, | | 28c. Injury at Work? | 28d. Describe how in | | |
| E After ding | 후 | 1 Natural 5 Pending 2 Accident investigatio | |) Injury M | Work? 1 ☐ Yes 2 ☐ No | | | |
| INITION OF ATTENDING Effer death. Director: After In by the fune | Certification: | 3 ☐ Suicide 6 ☐ Could not b | De Diana of Injury A | t home, farm, street, lac | | 28f. Location (Street | and Number or Dr | rai Pauta Numbas |
| or A lifer or by | E | 4 Homicide determined | building, etc. (Spe | ecify) | tory, onice | City or Town, Si | | irai Aobie Number, |
| itai irs e raf E | | | | | | | | |
| osp hou ly fil | cai | 29a. Certifier 1 Certifying Pl | hysician: To the best of my liminer: On the basis of exam | knowledge, death occurr | ed at the time, date and place | ce, and due to the cause | e(s) and manner as | stated. |
| To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the | edicai | one) | and manner stated. | | on, in my opinion, deam occ | osos ut trio tirito, dato | and place, and due | io ine canse(s) |
| To 11 Fo 11 | Σ | 29b. Signature and title of certifier | _ | | 29c. License number | 29d. | Date signed (Mont | h, Day, Year) |
| 4. | |) XX | | Mp | 11115 | 1. | 16/200 | 6 |
| (0 | | 30. Name and address of person who | completed cause of do-15 // | | 16610 | - 1(| 0, 200 | 0 |
| | | 1 0 1 | | | 1 A II | 44.0 | 3.1-1 | |
| | | 31. Date filed (Month, Day, Year) | 32 Registrar's Sig | | ne Street, Ball | myle MI) | aldol | |
| St Regist | ate | NOV 1 3 20 | 106 | H Localis | | | | |

| | | | 1 - For State Registrar | State of | Marylan | | artmen rtificat | | | | | giene Rag. No: | 006 | 37742 |
|---------------------|--|----------------|---|---------------------------------------|---|----------------------|--|--------------------|-------------------------------------|-------------|--------------------------------|------------------------------------|--------------------------|--|
| | DI | | 1. Decedent's Name (First, Middle, La | st) | | | | | | | 2. Date of De. Month | Day | Year | 3. Time of Death |
| | Physici /Medic | | LESTER TE | PPER | | | | | | | NOVEMBE | R 11, | 2006 | 12:30P M |
| | Examin | | 4a. Facility Name (If not institution, giv | e street and num | iber) | | 4b. City, | Town, or | Location of | of Death | | | ounty of Deat | |
| | | | 2707 NAVARRE DRIVE | | 7 A = 2 (1 - 1 - 1 - 1 | (a.a.) biathala | If Under | | CHASE If Under | | 8. Date of Birt | | ONTGOMER | |
| | Funeral | | 5. Social Security Number 6. S 161-16-5571 | ©XM 2□F | 7. Age (In yrs. _: 89 | | Months | Days | Hours | Min. | (Month, Da AUGUST 7 | y, Year) | Co | hplace (State or Foreign untry) YORK |
| | Director | | Usual Residence of Decedent | | | | | | | | 100001 7 | , 171, | 11211 | |
| | yland | | 10a. State 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | | | | 10d. Inside City Limits |
| | e-1 e | ctor | MARYLAND MONTGO | MERY | | CHE | VY CHA | SE_ | | | | | | 1 ☐ Yes 2 ☒ No |
| | or 28 | Director | 10e. Street and Number | | | | 10f. Zip | | | | | _ | en of What Co | |
| | ath w | | 2707 NAVARRE DRIVE | | | - 1 | | | 815 | | | | 4. Race - Ame | OF AMERICA |
| 36 | d within 72 hours after death with the Maryland Jone. Ir then "natural", or Iteme 23e or 23e-f ehow Itte Madical Examiner must be notified at | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced | Armed For | 2 □ No ARMY | | Was Deced If Yes, sped 1 ☐ Yes | cify Cuba | spanic On n, Mexicar Specify: | n, Puerto i | cify Yes or No Rican, etc.) | | Black, White | |
| 8 | tural | | 15. Decedent's E | Year or Da | IIWW | 16a. Dece | dent's Usua | al Occupa | ation | | | 16b. Kin | d of Business/ | Industry |
| 15 | n ne | plet | (Specify only highest gro | ade completed) | 4or E + \ | (Give | kind of wo DO NOT u | rk done a | <i>luring</i> mos | t of workir | ng | | | · |
| 212 | filed within Hygiene. Ither ther ther port, the Market here. | Completed | Elementary/Secondary (0-12) | College (1 5 | 401 5+) | ECO | NOMIST | | | | | U. | S. GOVER | NMENT |
| P | should be filed and Mental Hygian marked other matic event, I | BeC | 17. Father's Name (First, Middle, Last |) | | | | | 18. Mothe | er's Name | (First, Middle, | Maiden S | Sumame) | |
| <u>/a</u> | should be and Mental marked o | ဦ | HYMAN TEPPER | | | | | | | IDA i | HAUSLER | | | |
| Maryland 21215-0036 | 2 0 0 | | 19a. Informant's Name/Relationship (| Турө, Print) | | 19b. Maili | ng Address | (Street a | and Numbe | er or Rura | i Route Numb | er, City or | Town, State, 2 | Zip Code) |
| | 1 and 2 Health tem 27 | | JONATHAN B. TEPPER - | SON | 20h 5 | 18 ST | UART R | | NEWION | , | 02459 ate | 200 100 | ation - City or | Tourn State |
| Baltimore, | | | 20a. Method of Disposition 1 No Burial 2 Cremation 3 | | testa C | emetery, crei | matory or o | ther plac | e) | 11/13 | | | LPHI, MA | |
| Ē | t. Pa rtmen rtent: | | 4 ☐ Donation 5 ☐ Other (Special Service Lice | | 1111 | | | | | | | | | |
| Bal | permit. Page Department of Important: If eny Injury or once. | | 1 Solphan | | | 1 | .1800 N | EW HA | MPSHIR | RE AVE | . SILVER | SPRIN | | |
| | | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that ca one cause on ea | aused the deat ach line. | h. Do not ent | ter the mod | de of dyin | g, such as | cardiac o | r respiratory a | rrest, | | Approximate Interval Between Onset and Death |
| | Physician | 0 | Immediate Cause (Final disease or condition | CON | GESTIVE H | HEART FA | ILURE | | | | | | | Onset and Death WEEKS |
| | /Medical Examiner | | resulting in death) | Due to (| or as a conseq | uence of): | | | | | | | | |
| 8 | Examiner | ايا | Sequentially list conditions | D | AL FAILUI | | | | | | | _ | | MONTHS |
| | led Isit | Examine | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | D 00 10 (| or as a corrseq | abiles 01). | | | | | | | | |
| | axecu | xar | that initiated events resulting in death) Last | cDue to (| or as a conseq | uence of): | | | | | | | - | |
| 8760, | ate be executed hysician and the buriat-transit | dical | | d | | | | | | | | | | |
| 9 | ificate g phys as the | edi | | | | | | | | | | | | |
| O. Box | The law requires that the death certificate be executed tet has been signed by the attending physician and page 2 should be detached for use as the buriat-transit | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | | irth 2 ☐ Feta ant at time of d | I death 3 | ⊒Ectopic p ⊒ Other (s¢ | | | | | 20 | 3d. Date of dei Month | ivery Day Year |
| P.0 | thet the day the detached | | Part II. Other significant conditions | contributing to de | ath but not res | ulting in the u | inderlying o | ause give | en in Part I | ı. | 23e. Did t | obacco us | e contribute to | the cause of death? |
| sp. | uires sign lid be | d by | | | | | | | | | 1 🗆 ' | Yes 2□ | No 3□Pr | obably 4 XUnknown |
| of Vital Records, | w requ | Completed | | | | | | | | | 24a. Was | | 24b. Were au | itopsy findings available completion of cause of |
| æ | The lav | E O | | | | | | | | | autoj perfo | osy ormed? 2 \(\text{No} \) | death? | completion of cause of 2□ No |
| ta | | 0 | 25. Was case referred to medical | 3 | | | | | 26. Place | e of Death | (Check only | | | |
| * | S 0 7 | To B | examiner? 1 ☐ Yes 2 ☐ No | Hospital: 1 ☐ f | npatient 2 | ER/Outpatie | nt 3 DC | OA Othe | er: 4 □ Nu | ursing Hor | ne 5∐ Resi | dence 6 | □Other (Spe | cify) |
| 0 | ng Ph fter th inerat | ü | 27. Manner of Death 1 ⚠ Natural 5 ☐ Pending | 28a. Date of (Mont | of Injury h, Day Year) | 28b. Time o | | 28c. Injun Work | | | 28d. Describe | how injury | occurred | |
| Sio | Attending I ar death. ector: After by the funer | catl | 2 Accident investigated 3 Suicide 6 Could not t | | | | М | | Yes 2 | | | | | |
| Division | or Ati | Certification; | 4 Homicide determined | 288. Place | of Injury - At h ng, etc. <i>(Specii</i> | ome, farm, st (y) | reet, factor | y, office | | | 28f. Location (City or To | Street and wn, State) | Number or Hu | ural Route Number, |
| | pitel ours e eral f | | 29a. Certifier 1 Certifying P | hygician: To the | hest of my kor | wiedne deat | h occurred | at the tin | ne date ar | nd place | and due to the | cause(e) | and manner as | stated |
| | To the Hospitel or Attending Phywithin 24 hours efter death. To the Funeral Director: After thi | Medical | (Check only one) | miner: On the ba | | | | | | | | | | |
| | ompl | Me | 29b. Signature and title of certifier | 0 | | | 29 | c. License | e number | | | 29d. Date | signed (Mont | h, Day, Year) |
| | | | VOODE K | feren | . 0 | 7 | | Do | 169 | 59 | | NOV | EMBER 12 | , 2006 |
| | 3 | | 30. Name and address of person who | completed caus | e of death (Iter | n 23a) (Type, | Print) | | | | | | | |
| | | | ELIZA J. MARTINEZ | Z MD | 8808 HID | DEN HILI | LANE, | POT | OMAC, | MD 20 | 854 | | | |
| | | ate | 31. Date filed (Month, Day, Year) | | egistrar's Signa | ature A | acti | | | | | | | |
| | Regist | rar | NOV 13 | 2006 | MILLES & | Ch A | A STATE OF THE PARTY OF THE PAR | | | | | | | |

06-08504 Phillip Ayiku

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

| | | I- For State Registrar | Cer | rtificate of | Death | | eg No. 200 | 3//4 |
|--|---------------|--|---|----------------------------------|---|---|--|--|
| Physiciar Medical Examin | er | | | etteh | | 2. Date of Dea Month Novembe | Day Year 8, 2006 | 3. Time of Death 1207 hrs |
| } | ı | 4a. Facility Name (if not institution, give street Shady Grove Hospital | and number) | 4 | o. City, Town, or Location Rockville | of Death | 4c County of Death Montgomery | |
| Funeral Director | | 5. Social Security Number 6. Sex 214-77-1038 1 May 2 Usual Residence of Decedent | 7. Age (In yrs. la | ast birthday) Yrs. | Months Days Hour | s Min | th(MM/DD/YYYY) 9 Birt Foreig Cou | |
| Maryland 28a-f show any 1 at once. | Ī | MD 10b. County Montgomer | | Town or Location | sburg | | | 10d. Inside City Limits 1 Yes 2 No |
| ith the Maryland 23a or 28a-f sho notified at once. | <u>=</u> | 10e. Street and Number 11575 Sullnick Wa | ay | | 10f. Zip Code 20878 | | 0g Citizen of What Cour | try'? |
| er death wi | by Funeral | | /as Decedent Ever in U. rmed Forces? Yes 2 X No Give Year ss: | If Ye | Decedent of Hispanic Ors, specify Cuban, Mexical Yes 2 X No specify | n, Puerto Rican, etc.) | White, etc. | an Indian, Black, ack |
| 336 thin 72 hours ne than "natur edical Exam | Completed | 15. Decedent's Education (Specify only high Elementary/Secondary (0-12) O | est grade completed) llege (1-4 or 5+) | | s Usual Occupation (Give st of working life. DO NOT | | 16b Kind of Business/II | ndustry |
| ore, MD 21215-0036 es 1 and 2 should be filed within 7 of Health and Mental Hygiene If item 27 is marked other than her traumatic event, the Medica | | 17. Father's Name (First, Middle, Last) | | _ | | r's Name (First, Middle, M | | |
| 212 ould be I Menta marke | To Be | Gilbert Tetteh 19a Informant's Name/Relationship (Type, Pr | int) | 19b. Mailing | Pat Address (Street and Nu | ience Avi mber or Rural Route Nun | k u nber, City or Town, State, | Zıp Code) |
| 두 당분 등 등 | | Gilbert Tetteh/Fa | | 115 | 75 Sullnic | k Way Gai | thersburg | Md 20878 |
| rent Bag | | 1 X Burial 2 Cremation 3 Rer 4 Donation 5 Other Sector | noval from State Ga | ate of | Heaven | 11/18/06 | Silver Sp | oring,Md. |
| Balti permit. Departm Imports injury o | | 21. Styr ture of Funeral Service Licensee 23a. Part I. Eyter the disease, or complication | | PH 1924 | LIP D.RIN 11 Columbi | ÄLDI FUNE a Blvd Si | RAL SERVIC | CE, P.A. |
| Physician /Medical | | failure. List only one cause on each line. | | | e mode of dying, such as lisease complic | | | Approximate Interval Between Onset and Death |
| xaminer | İ | or condition resulting in death) Due to | (or as a consequence o | n: aspirati | on pneumonia | | | |
| | iner | cause Enter Underlying Cause | (or as a consequence o | f): | | | | |
| cuted md transit | Examiner | (Disease or injury that initiated events resulting in death) Last C. Due to | (or as a consequence o | f): | | | | - |
| an a | dical | | NDE3a,27,28a-1 | f, perÆ, | g865, 3/2/07 T | T | | |
| ox 68 | sician/I | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | If yes, outcome of preg Live birth Pregnant at time of de | nancy 2 Feta | al death 3 Ectop | | 23d. Date of delivery Month D | ay Year |
| P,O, B(| 좕 | Part II. Other significant conditions contrib | Unknown outing to death but not re | esulting in the ur | nderlying cause given in P | art I. 23e. Did to | bacco use contribute to t | he cause of death? |
| ords, P.C. | ted by | | | | | 1 Yes | 2 ✓ No 3 Prob | opsy findings available |
| Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be a been should be a supplementation of the funeral director. | Completed | | | | | autop perfor 1 ✓ Yes | sy prior to co med? death? | ompletion of cause of |
| tal Rec | Be C | 25. Was case referred to medical examiner? | | | 26.Place of Death | (Check only one) | | |
| n of Vit ling Physic After this | e | 1 ✓ Yes 2 No | a. Date of Injury | ER/Outpatient 28b. Time of In | | k? 28d Describe I | Residence 6 Others | |
| ision (Attending r death. rector: Af | ation | 1 Natural E | (Month, Day,Year) 0/25/2006 | unk. | 1 Yes 2 X | Complicat placement | ions of surgic | al stent |
| Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the | Certification | 3 Suicide 6 Could not be determined (S | se. Place of Injury - At h | | , factory, office building, e | etc. 28f. Location (\$ or Town, S washingto | Street and Number of Rur tate) 111 Michiga n, D.C. | al Route Number, City n Ave. NW |
| 8 ± = 5 | Medical | 29a. Certifier 1 Certifying Physician: To Check only one) 7 Medical Examiner:On the and m | | | | | | |
| FAFO | ž | 29b/9 gnature and title of certifier |) | | 29c. License number O.C.M.E. | | 29d Date signed (Mon | |
| | | 30 Name and address of person who comple | ed cause of death (Item | 1 23a) | 0.0.W.L. | | | |
| | | | ledical Examiner | | Street, Baltimore, N | 1D 21201 | | |
| Sta Registr | ite rar | 31. Date filed (NOV Dag Yeg) 2006 | 3. Registrar's Signatu | Apart | | | | |

| | | 1 | For State Registrar | State of Maryland / | | rtment of tificate o | | | | iene, 006 | 37744 |
|----------------|---|-----------------|--|---|---------------------------|---------------------------------------|-----------------------------------|------------------------------|-----------------------------------|---|---|
| 2 | | _ | . Decedent's Name (First, Middle, Last) | | | | | | Date of Deat Month | Day Year | |
| | Physicia /Medic | al | Virginia E. Thax | | | | | | ovemb | er 4 200 | |
| | Examin | 5 1 | a. Facility Name (If not institution, give s | | | 4b. City, Town | | | | Anne A | |
| 1) l2 | Formul | | 7900 Benesch Cin | 7. Age (In yrs. last | birthday) | If Under 1 Ye | ar If Under | | . Date of Birth | 9 Bi | rthplace (State or Foreign |
| | Funeral Director | | 212-34-3061 | M 2CXF 72 | Yrs. | Months Day | /s Hours | | Month, Day, pr 20 | 1934 Ma | ryland |
| | B & 33 | - | Usuaf Residence of Decedent 10a. State 10b. County | 10c. City, To | own or Lo | cation | | | _ | | 10d. fnside City Limits |
| | f sho | | aryland Anne Art | undel Gle | en B | urnie | | | | | 1 ☐ Yes 2X No |
| | r 28e | Irec | 10e. Street and Number | | | 10f. Zip Cod | | | 1 | log. Citizen of What (| Country? |
| | death with the maryland ms 23s or 28e-f show | Funeral Directo | 7900 Benesch Cit | | 1 | 210 | | | | USA | nerican Indian, |
| | tema tema | nue | 11. Walkar States | 2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No | 13. \ | Was Decedent of f Yes, specify C | of Hispanic Ori Suban, Mexical | igin? (Speci n, Puerto Ri | can, etc.) | Black, Wh | nite, etc. |
| 50 | hours after turni', or its | by F | 1 Never Married 2 Married 3 Widowed 4 Divorced | ff Yes, Give Year or Dates: | | 1 ☐ Yes 2 ☐X | No Specify: | | | Specify: | Black |
| | | | 15. Decedent's Educ (Specify only highest grade | | (Give | dent's Usuaf Oc kind of work do | ne during mos | st of working | , | 16b. Kind of Busines | |
| 7 | within 72 ene. than "na te Miolic | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | life. I | oo NOT use re ustodi | tired) | | | Bowie St Universi | |
| | filed w Hygier other th | | 12th 17. Father's Name (First, Middle, Last) | 0 | | ustoui | | er's Name (| | Maiden Sumame) | |
| ⊆ : | d be f | To Be | Horace Larkins | | | | Li | ll iar | wall | ace | |
| کے | s 1 and 2 should if Health and Men item 27 is marke other traumatic | F | 19a. Informant's Name/Relationship (Ty | | | | | | | r, City or Town, State | |
| | and 2 Baith a n 27 is | | Minion Contee(S | | | | | | | Md. 211 | |
| 5 | | | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R | | | sition (Name o | | Da | | 20c. Location - City | |
| Ē | nit. Pages vartment of ortant: If it injury or o | | 4 ☐ Donation 5 ☐ Other (Specify) | Zio | | urch | | 11-11 | | Odenton, | |
| Ba | permit. Page Department of Important: If any injury of once. | | 21. Signature of Funeral Service License | MA0483 | | | | | | nary, P.A , Md. 21 | |
| | | | 23a. Part1. Enter the disease, or compli | cations that caused the death. | Do not en | ter the mode of | dying, such as | s cardiac or | respiratory ar | rest, | Approximate Interval Between |
| 1 | Physician /Medical Examiner | | shock, or heart failure. List only or fmmediate Cause (Final disease or condition resulting in death) | Due to (or as consequer | try | dy | ye' | | | | Onset and Death |
| 760, | te be executed ysicien and le burial-transit | cal Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | Due to (or as a consequer Due to (or as a consequer d. | | | | | | | |
| .O. Box 68 | The law requires that the death certifica tie hes been signed by the ettending ph page 2 should be detached for use as th | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 23c. If yes, outcome of pregnanc 1 Live birth 2 Fetaf de 4 Pregnant at time of deal | eath 3(| □Ectopic pregn □ Other (specif | | | | 23d. Date of Month | delivery Day Year |
| ٥. | uires that I signed by Id be deta | | Part ff. Other significent conditions co | nthouting to death but not resulti | ing in the u | underlying caus | e given in Part | 11. | 23e. Did t | And | e to the cause of death? Probably 4 □Unknown |
| Vital Records, | The law require rate hes been si page 2 should I | Completed by | | J// V | | | | | 24a. Was autor perfo | an 24b. Were prior death 2 200 No 1 1 1 | |
| ta | | 0 | 25. Was case referred to medical | | | | 26. Pla | ce of Death | (Check only o | | |
| Ţ | W . | To B | examiner? 1 ☐ Yes 25€No | | R/Outpatie | | | | | dence 6 Other (S | Specify) |
| n of | | | 27. Manner of Death 1 Natural 5 Pending | 28a. Date of Injury (Month, Day Year) | 8b. Time Injury | of 28c. | Injury at Work? | | 8d. Describe | how injury occurred | |
| Division | Attending or death. | ertification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of fnjury - At hom building, etc. (Specify) | ne, farm, s | | | | 28f. Location (City or To | | r Rural Route Number, |
| ۵ | To the Hospitel or Attendenthin 24 hours after death To the Funeral Director: completely filled in by the | edicai Cer | 20a Contilion 1 Contifuing Phy | vsician: To the best of my knowliner: On the basis of examination | ledge, dea on and/or i | ith occurred at t nvestigation, in | he time, date a my opinion, de | and place, a eath occurre | and due to the ed at the time, | cause(s) and manne date and place, and | r as stated. due to the cause(s) |
| \ | To the Within 2 To the comple | Mec | 29b. Signature and title of certifier | 1 | | 29c. L | icense numbe | - | | 29d. Date signed (M | onth, Day, Year) |
| | | | 30. Name and address of person who | completed cause of death (Item 2 | 23а) (Туре | a, Print) | ^ | 0.1 | 2 1 | | 1061 |
| 2 | 7) | oto | 31. Datefiled (Month, Day Year) | 37 Registrar's Signatu | aire | Mychin | in co | N VE | Em Bu | unu MI | 01001 |
| 150.3 14. | Regis | tate trar | NOV 0 8 20 | 106 See 1 | 1 | now ! | V | | | | |

| | | | For State Registrar | State of Man | | artment of H tificate of L | | | ene g. No.2 0 0 6 | 37745 |
|---------------|--|---------------------|---|--|-------------------------------------|---|--|---|---|---|
| | Physicia | an | 1. Decedent's Name (First, Middle, Last | W ' | TEAT | J | R | 2. Date of Death Month | 83 2000 | 3. Time of Death |
| | /Medic Examin | er | 4a. Facility Name (If not institution, give 219 A Bloomsbur 5. Social Security Number 6. Se | y Square | in yrs. last birthday) | Annapo | | 8. Date of Birth | 4c. County of Deat Anne Ai | |
| | Funeral Director | | 217-62-9799 Usual Residence of Decedent 10a. State 10b. County | 7. Age (I | 5 1 ^{Yrs.} | Months Days | Hours Min. | Nov 9 1 | 954 D.C | 10d. Inside City Limits |
| | the Maryla 28a-f shov | ector | Maryland Anne Ar | | Annapol | | | 10 | g. Citizen of What Co | Yes 2 No |
| 36 | s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Madical Examinar must be notified at | by Funeral Director | 219 A Bloomsbur 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | y Square 12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 214() Was Decedent of H | 1 lispanic Origin? (Spec an, Mexican, Puerto F Specify: | | USA 14. Race - Ame Black, Whit | erican Indian, |
| d 21215-0036 | filed within 72 hou Hygiene. Ither then "nature ent, the Medical E | Completed | 15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 11th | | (Give life. I | dent's Usual Occupi kind of work done of DO NOT use retired | durina most of workin | 9 1 | 6b. Kind of Business. Anne Arun Public Wo (aiden Sumame) | ndel Co. |
| Maryland | should be nd Mental marked o | To Be | Clayton W. Teat | | 19b. Mailir | ng Address (Street | Melvani | | Ey City or Town, State, . | Zip Code) |
| Baltimore, Ma | Page nent o ant: If ury or | | Betty Marie Tea 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify | at (Wife) | | A Bloom | sbury Sq | uare An | nnapolis Oc. Location - City or Annapolis | , Md. 2140 Town, State |
| Balti | permit. Pag Department Important: I any Injury o | | 21. Signature of Funeral Service Licentary 13. | eese Mcox | 83 8 | 21 West | St. Ann | <u>apolis</u> | ary, P.A , Md. 21 | 401 |
| <i>y</i> | Physician /Medical Examiner | ner | 23a. Part1. Enter the disease, or compensors, or heart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury | b. Due to (or as a c | consequence of): | er the mode of dying the Sept | ickence | Laile Laile | M. | Approximate Interval Between Onset and Death 3 (Vel) |
| 8760, | death certificate be executed e attending physician and of for use as the burial-transit | dicai Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a c | consequence of): | o aleu | MTL | | | yeur |
| O. Box 6 | that the death certifics ed by the attending pl detached for use as t | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of 1 □ Live birth 2 ! 4 □ Pregnant at tin 9 □ Unknown | Fetal death 3 | Ectopic pregnancy Other (specify) | у | | 23d. Date of de Month | livery Day Year |
| α. | sign Sign I be | þ | Part II. Other significant conditions of | ontributing to death but | not resulting in the u | nderlying cause giv | ven in Part I. | 23e. Did tob | 0 | o the cause of death? |
| Il Records, | The law ate has b page 2 sl | Completed | | | | | | 24a. Was an autopsy perform | prior to death? | utopsy findings available completion of cause of s 2 No |
| Vital | Physician: Th this certificate ral director, pag | o Be | 25. Was case referred to medical examiner? | Hospital: | αΠ <i>Ε</i> Ρ/Ω | oth Oth | 26. Place of Death | - 1 | | |
| of | To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director. | H- | 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day) | | f 28c. Injur | 4 U Nursing non | | nce 6 □Other (Spe w injury occurred | (City) |
| Division | tel or Atte s after de si Directo ed in by th | Certification; | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury building, etc. | y - At home, farm, sti (Specify) | reet, factory, office | 2 | 28f. Location (Str City or Town, | eet and Number or R , State) | ural Route Number, |
| | ne Kospitel n 24 hours i he Funers! pletely filled | edical | 29a. Certifier Check only one) 29a. Certifying Ph | ysician: To the best of niner: On the basis of e and manner state | xamination and/or in | h occurred at the tire exestigation, in my o | me, date and place, a ppinion, death occurre | and due to the ca ad at the time, da | use(s) and manner a ite and place, and du | s stated. e to the cause(s) |
| | To the within 2 To the complei | M | 29b. Signature and title of certifie | J Ho | wan | 29c. Licens | 2/438 | | od. Date/signed (Mon | 0306 |
| _ | 3 | | 30. Name and address of person why MICHAR J. Lat | MATTA | 447 1 | Print) EFENSE | HI GHWA | ty Ana | Apols M | 02401 |
| (9 | St Regist | ate rar | 31. Date filed (Month, Day, Year) NOV 0 8 | 2006 32. Rigistrar | s Signature | beck | | | | |

State of Maryland / Department of Health and Mental Hygier (2) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ν. 5, 9:45 P Raymond Thomas November 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3940 Bexley Place Suitland Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 28, 1 Funeral Birthplace (State or Foreign Country) Days Hours 1⊠M 2□F Yrs Director 220-28-5037 74 1932 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Maryland Prince Georges Suitland 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3940 Bexley Place 20746 United States or items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene.
Hygiene.
Ither then "neturel", or ite 1 Never Married 2 Married 1⊠Yes 2□No 1952 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Depertment of Health and Mental Hygiene Important: if item 27 is marked other tha any injury or other traumatic event, Ital, ODGs. 9th Laborer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Paul V. Thomas Louise Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary T. Thomas/Spouse 3940 Bexley Place, Suitland, Md. 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem. Nov. 15,2006 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD. Funeral Homes Marlboro Pike 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Forestville, Md. 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mer 5200 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a Examiner attending physician and for use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a conseq nce of Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the a 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 → Hinknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? mied? No perforni certificete 1 🗌 Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death | Check only one examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 📜 No 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred After s effer dec. 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours of Funeral Di letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Chack only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 23826 cause of death (Item 23a) (Pipe, Print) 30. Name and address of person who come end 7700 Old Branch Ave. Suite B201; Clinton, Md. Glenn Edgecombe, M.D. 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

State of Maryland / Department of Health and Mental Hygien 006

| 4 > | | State Registrar | | | | Cei | rtificat | e of L | Death | | | Reg. N | 0. | | | |
|--|----------------------|---|--|---|--|---|-------------------------------------|--|---|--------------------------|---|-------------------------------|-----------------------|---------------------------------|---|--|
| | | Decedent's Name (First, Middentification) | de, Last) | | | | | | | | 2. Date of De | eath | 3. Time of | | 3. Time of Death | |
| Physicia /Medic | _ | Lais | æ | Ε. | Γ | homas | | | | | Novembe | r 1, | 2006 | Year | 7:15 P. | |
| Examin | | 4a. Facility Name (If not institution Holy Cross Hospit | | reet and nu | mber) | | 4b. City, | | Location o | | | | c. County | | | |
| Funeral Director | | 5. Social Security Number 220-40-5453 | 6. Sex | м 2 %] F | 7. Age (In yrs 64 | . last birthday) Yrs. | If Under Months | 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bir Month, Da December | rth ay, Yea, IT 7, | 1941 | | place (State or Fore | |
| *** | | Usual Residence of Decedent 10a. State 10b. Count | v | | 10c. C | ity, Town or La | cation | | | 10d. Inside City Limits | | | | | | |
| ohe | 5 | | | 1 . | | my, rown or Lo | _ | 1 | | | | | | | 12⊠2Yes 2 🗌 | |
| 28a-1 | Director | Maryland Prince | e Geor | gers | | | Laur 10f. Zip | | | | | 10- 0 | litizen of V | | | |
| ne then "natural", or iteme 23a or 28a-f ahow he Medical Examinar must be notified at | rai Dir | 7901 Laurel | | | | | 101. Zip | Code | 20 | 707 | | 10g. C | U.S. | Α. | | |
| Department of Health and Mental Hygiene. Importent: If Item 27 ie marked other then "natural", or Iteme 23s or 28s-f ahow any injury or other traumatic event, the Madical Examinat must be notified at once. | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed XX Divorce | rried | Was Dec Armed For 1 ☐ Yes If Yes, Gir Year or D | 2 (Z)No ve | | Was Deced If Yes, spec 1 Yes | cify Cuba | spanic Ori n, Mexican Specify: | gin? (Spe n, Puerto f | cify Yes or No Rican, etc.) | 0- | Blac | e - Amend k, White, Black | | |
| dical | Completed | 15. Decede (Specify only high | nt's Educ | ation completed) | | 16a. Dece | kind of wo | rk done c | turing mos | t of workir | ia . | 16b. | Kind of Bu | isiness/In | dustry | |
| P P P | mpi | Elementary/Secondary (0-12) | 10 | College (| 1-4or 5+) | life. | DO NOT u | se retired |) - | | | D. | C C~ | | ~ t - | |
| tygie nt, th | ပ္ပ | 9th grac | | | | | Food S | ervio | | | /Ci 141-4-11- | | C. Gov | | | |
| d of | Be | | | rrison | | | | | 18. Mothe | | (First, Middle rginia I | | | Θ) | | |
| d Mer nark natic | 2 | 19a. Informant's Name/Relation | - | | | 106 Mailie | | (011 | | | | | | Q | | |
| n 27 ie r | | Mary Thompson (Sis | | | | 1511 I | warren | Aven | ue Lan | dover | , Maryla | nd 2 | 20785 | State, Zip | Code) | |
| nent of Hi int: if iter iry or oth | | 20a. Method of Disposition 1 □ Q Burial 2 □ Cremation 4 □ Donation 5 □ Other (| | moval from | State | Place of Dispo cemetery, crer MONY Men | natory or o | ther plac | | | 8, 200 | | dover | • | | |
| Departn imports any inju | 1 | 21. Signature of Funer II Service | e License | Pour | 11 | 57/0 | 2. Name an | | | I | ollins F | | | | с. | |
| | Medical Examiner | shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. b. c. d. | Hepe Due to End Due to | tic Ence | ver Dise quence of): rrhosis | • | | | | | | | | Interval Between Onset and Death | |
| | by Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23 | 1 Live t | tcome of pregr birth 2 Per nant at time of own | tal death 3 | Ectopic pr Other (sp | | | | | | 23d, Date Mor | e of delive | ery Day Year | |
| signed by | | Part II. Other significant condit | tions cont | ons contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use | | | | | | | | | ne cause of death? | | | |
| been signed by the etten should be detached for u | lete | | | | | | _ | | | | 24a. Was | | Part of the | | - | |
| has b | Completed | | | | | | | | | | auto | | d | rior to cor leath? | psy findings availal mpletion of cause of 2[XNo | |
| cate pa(| - | OF IAI. | | | | | | 1 | | of Death | Check only | one) | | | | |
| ertificate ector, pag | Be | 25. Was case referred to medic examiner? | examiner? 1 Tyes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | | | | | | | | Other | | | | | |
| ing rnysicien: The i | To Be | examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑Natural 5 ☐ Pend | ing | | of Injury th, Day Year) | Injury | | | | | | | | | | |
| s effer deeth. el Director: After this certificate ed in by the funeral director, pa | To Be | examiner? 1 | ing tigation | 28a. Date (Mon | | Injury | М | 10 | (? Yes 2 □ I | | 8f. Location (City or To | Street a wn, Stai | und Numbe te) | ar or Rura | l Route Number, | |
| nospiral of Available 1. 124 hours effer deeth. • Funerel Director: After this certificate letely filled in by the funeral director, pag | Certification: To Be | examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Couk 4 Homicide deter | ing tigation d not be mined | 28a. Date (Mon 28e. Place build cian: To the er: On the b | of Injury - At ing, etc. (Spec | Injury | M eet, factory | 1 [] \ | Yes 2 □ I | d place, a | City or To | wn, Stai | te) | nner as st | ated | |
| re effect deeth. Tel Director: After this certification by the funeral director. | To Be | examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend inves 3 Suicide 6 Could deter 29a. Certifier 1 Check only 2 Medica | ing tigation d not be mined ing Physi | 28a. Date (Mon 28e. Place build cian: To the er: On the b | of Injury - Ating, etc. (Special best of my knass of examination o | Injury home, farm, str | M eet, factory | 1 (), office at the tim , in my op | Yes 2 1 | d place, a | City or To | cause(s date ar 29d. Da | s) and maind place, a | nner as st and due to | ated. the cause(s) Day, Year) | |
| within 24 hours effer deeth. To the Funerel Director: After this certificate completely filled in by the funeral director, par | Certification: To Be | examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend inves 3 Suicide 6 Could deter 29a. Certifier (Check only one) 1 X Certify 2 Medica | ing tigation d not be mined ing Physi | 28a. Date (Mon 28e. Place build cian: To the er: On the b | of Injury - Ating, etc. (Special best of my knass of examination o | Injury home, farm, str | M eet, factory | 1 (), office at the tim , in my op | Yes 2 □ I ne, date an pinion, dea | d place, a | City or To | cause(s date ar 29d. Da | s) and maind place, a | nner as st and due to | tated. the cause(s) Day, Year) | |
| within 24 hours effer deeth. To the Funerel Director: After this certificate completely filled in by the funeral director, pag | Certification: To Be | examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend inves 3 Suicide 6 Could deter 29a. Certifier (Check only one) 1 X Certify 2 Medica | ing tigation of not be mined ing Physial Exeminater | 28a. Date (Mon 28e. Place build cian: To the er: On the band man end end end end end end end end end en | e of Injury - At ing, etc. (Special Special Sp | Injury home, farm, str nowledge, death nation and/or in am 23a) (Type, | M eet, factory | 1 (), office at the tim, in my of | res 2 1 | d place, a | City or To | cause(s date ar 29d. Da | s) and maind place, a | nner as st and due to | ated. the cause(s) Day, Year) | |

| | | | | artment of Health and Me ertificate of Death | ntal Hygien | 7000 31140 |
|------------|--|----------------|--|--|---|---|
| | | | Decedent's Name (First, Middle, Last) | 2 | Date of Death Month Da | 3. Time of Death |
| | Physicia /Medic | | HELEN MacMILLAN VERZI | 1 | lovember. | |
| | Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 40 | c. County of Death |
| | | | WASHINGTON COUNTY HOSPITAL | HAGERSTOWN | | WASHINGTON |
| | Funeral | | 5. Social Security Number 6. Sex 1 | If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min. | . Date of Birth (Month, Day, Year | 9. Birthplace (State or Foreign Country) |
| | Director | | 5/7-32-830/ 79 | D | ECEMBER 17, | 1926 ILLINOIS |
| | Mc H | 1 | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I | ocation | | 10d. Inside City Limits |
| | Many 1 • h | ρ | MARYLAND WASHINGTON | HAGERSTOWN | | 1 ☐ Yes 2 🖾 No |
| | r 28a | Director | 10e. Street and Number | 10f. Zip Code | 10g. C | itizen of What Country? |
| | h with | O O | 20303 AYOUB LANE | 21742 | : | U.S.A. |
| | deel | ner | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? | . Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Mexican, Puerto Ri | fy Yes or No- can, etc.) | 14. Race - American Indian, Black, White, etc. |
| 98 | be filed within 72 hours after deeth with the Marylend ital Hygiene. Id other then "natural", or iteme 23e or 28e-f ehow event, the Madical Esphinstransi Le notified at | by Funerai | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No | 1 ☐ Yes 2 No Specify: | | Specify: |
| 21215-0036 | hour: | d b | 3 ☐ Widowed 4 ⚠ Divorced Year or Dates: 15. Decedent's Education 16a. Dec | edent's Usual Occupation | 16b l | WHITE Kind of Business/Industry |
| 5 | in 72 in n | Completed | (Specify only highest grade completed) (Giv | e kind of work done during most of working DO NOT use retired) | 1 | , |
| 72 | d within piene. r then " | E | Elementary/Secondary (0-12) College (1-4or 5+) 5+ | REGISTERED DIETICIAN | 1 | HEALTHCARE SERVICES |
| ਰੂ | e filed within al Hygiene. I other then ' vent, ine Ma | 0 | 17. Father's Name (First, Middle, Last) | 18. Mother's Name (| First, Middle, Maide | en Sumame) |
| <u>la</u> | should be nd Mental marked o matic eve | To B | LAWRENCE CLAUDE MacMILLAN | OLG | A MUELLER | |
| Maryland | s 1 and 2 should f Health and Men Item 27 le marke other treumatic | | 19a. Informant's Name/Relationship (Type, Print) | ling Address (Street and Number or Rural I | Route Number, City | or Town, State, Zip Code) |
| | and ealth m 27 | ı | | O3 AYOUB LANE, HAGERSTOW | | |
| ore | | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cometery, cr | ematory or other place) | 19 20C. L | Location - City or Town, State |
| Ē | tmen tant: | | | EMORIAL PARK 11/18/ | 2006 RO | CKVILLE, MARYLAND |
| Baltimore, | permit. Page Department of Important: If any Injury or | | | 22. Name and Address of Facility HINES-RINALDI FUNERAL HO 11800 NEW HAMPSHIRE AVEN | ME, INC. UE, SILVER S | SPRING, MARYLAND 20904 |
| | | | 23a. Part1. Enter the disease, or complications that ceused the death. Do not e shock, or been failure. List only one cause on each line. | nter the mode of dying, such as cardiac or | respiratory arrest, | Approximate Interval Between |
| | Physician | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) Due to (or as a consequence of): | | | |
| | LAdimine | _ | Sequentially list conditions, b. Cardi's sen | i'c shock | | |
| | ted nsit | nine | if any, leading to immediate cause. Enter Underlying cause (Disease or injury | cordial infadic shock | | |
| | al-tra | Examiner | that initiated events c. resulting in death) Last C. Due to (or as a c. sequence of): | in farmer | | |
| 38760, | ficate be executed physicien and s the burial-transit | dicail | d. | | | |
| - | tificat g phy as th | | TO STATE OF THE ST | | | |
| Вох | eath certifi attending I for use as | an/N | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 | □Ectopic pregnancy | 1 | 23d. Date of delivery Month Day Year |
| ю. П | The law requires that the death certif ste has been signed by the attending page 2 should be detached for use a | Physician/M | in the past 12 months? 1 | Other (specify) | | month bay roa. |
| Δ. | that the ed by detact | | Part II. Other significant conditions contributing to death but not resulting in the | underlying cause given in Part I. | 23e. Did tobacco | use contribute to the cause of death? |
| Records, | signé d be | d by | huantensia comman a | when diseran | 1 ☐ Yes | 2 No 3 Probably 4 Ponknown |
| 50 | w requir been si should | Completed | D = 11 = 11 = 11. | | 24a. Was an | 24b. Were autopsy findings available |
| Re | The lav | E C | Tenentia, hope the man | | autopsy performed? | |
| Vital | | 0 | 25. Was case referred to medical | 26. Place of Death | 1 ☐ Yes 2 ☑ ✓ 'Check only one) | 10 163 20 10 |
| \leq | Physician: r this certific ral director, | 9 | examiner? 1 Yes 2 Yo | ent 3 DOA Other: 4 Nursing Hom | e 5 Residence | 6 ☐Other (Specify) |
| J Of | ding Ph h. After th funeral | ä | 27. Manner of Death 1 CNatural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time (Injury) | | d. Describe how inj | ury occurred |
| <u>S</u> | endir eath. or: Al | atic | 2 Accident investigation | M 1 ☐ Yes 2 ☐ No | | |
| Division | To the Hospital or Attending P. within 24 hours effer death. To the Funeral Director: After the completely filled in by the funeral | Certification; | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) | street, factory, office | 31. Location (Street a City or Town, Sta | and Number or Rural Route Number, ite) |
| _ | spits nerei | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge de | | | |
| | n 24 h | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated. | investigation, in my opinion, death occurred | at the time, date ar | nd place, and due to the cause(s) |
| | To the To the Comp | Σ | 29b. Signature and title of certifier | 29c. License number | | Date signed (Month, Day, Year) |
| | 5 | | masus, no | D62588 | No | Vender 11H, 2006 |
| | _ | | 30. Name and address of person who completed cause of death (Item 23a) (Typ JUDITH MBAOUA, MB. 751 E. 4 | a, Print) nticham st. Hage | retown, | 70 |
| | Sta | ate | | | · · · · · · · · · · · · · · · · · · · | |
| | Regist | rar | NOV 1 3 2006 32 Registrar's Signature | are | | |

State of Maryland / Department of Health and Mental Hygiene 37749 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Katherine Isham White Nov. 8. 2006 9:20 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6540 Walhonding Road Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 E Director 323-38-2463 67 1939 Illinois 18, Usual Residence of Decedent 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 ie marked other then "neturel", or items 23a or 28a-1 ehow eny injuty acryther traumatic event, the Medical Examinar must be notified at once. 10d. Inside City Limits 1X Yes 2 □ No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6540 Walhonding Road U.S.A. Completed by Funeral 20816 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Registered Nurse Public Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Ralph N. Isham Eleanor I. Dennehy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony W. White / Husband 6540 Walhonding Rd. Bethesda, Maryland 20816 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 I Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory Nov. 12,06 Falls Church, Va 21. Signature of Funeral Service License 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic Bone Bre **Physician** aları /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 Probably 4 □Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform his certificete I 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 TResidence 6 Other (Specify) Certification: To 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the hours efter death 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (Type, Print) Medica Oncolog 31. Date filed (Month, Day, Year) State 13 2006 Registrar

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 0 0 6 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** November 4, 2006 8:00 A M Patricia Hawkes Williams /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 455 Honereng Trail Annapolis If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6 Sex **Funeral** 1□M 2₩F Days Hours 78 Director 579-36-2233 6/24/1928 Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "naturel", or iteme 23s or 28s-f ehow any injury or other traumatic event, the Medical Examples required a page. Annapolis 1 ☐ Yes 2 X No Anne Arundel Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 USA 455 Honereng Trail Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 NWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Elections Official MD Election Board vears 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nellie Harston Frederick Hawkes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3600 Preddy Creek Rd., Charlottesville, VA 22911 Arthur G. Williams/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 【***Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-6-06 Edgewater, MD Kalas Crematory 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final anæv **Physician** 2 MOS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The lew requires that the death certificate be executed use as the burial-transit attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 gronths?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ bage 2 should be 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy this certificate has 1 Yes 2 No After this certifice funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital Territying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the nause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) 29b. Signature and fitte of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) Selonick, mo 9030. Name and address of pe 900 Bestgate Rd. Annapolis Und 32. Pigistrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 8 2006 Registrar

| | | 1 - For State Registrar | State of Mary | land / Depa <i>Cei</i> | artment of H | lealth and Death | d Mental H | | 16 | 37752 |
|---|---------------------|--|---|---|---|--|--|---|---|--|
| Physic | ian | Decedent's Name (First, Middle, L. | | | | | 2. Date of Month | . Dav | Year | 3. Time of Death |
| /Med Exami | ical | 4a. Facility Name (If not institution, gr | eveland Winds ve street and number) every 4/65 | sor soila/ | 4b. City, Town, or | Location of De | Novem | berog. | 2006 y of Death | 1033a |
| Funera Director | | 5. Social Security Number 6. 215–28–6606 | | yrs. last birthday) 77 Yrs. | If Under 1 Year Months Days | If Under 24 H Hours M | in. (Month, | | 9. Birfhi | place (State or Forei ntry) ryland |
| arylend ehow | _ | Usual Residence of Decedent 10a. State 10b. County MD Dorche | | . City, Town or Lo | cation Cambr | idae | | | | 10d. Inside City Limit |
| vith the M or 28a-f | Directo | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of | | |
| 15-0036 n 72 hours efter deeth with the Marylend "neturel", or lieme 23a or 28a-f ehow salical Examinar must be notilised at | by Funeral Director | 5303 Spring Dr 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates: | - 1 | Vas Decedent of H f Yes, specify Cuba | 1613 spanic Origin? n, Mexican, Pu Specify: | (Specify Yes or lerto Rican, etc.) | Bla | USA ce - Americ ck, White, fy: wh: | |
| (1215-0036 within 72 hours eff ene. then "neturel", or the Medical Exerci- | Completed | 15. Decedent's (Specify only highest g Elementary/Secondary (0-12) | | (Give | lent's Usual Occupa kind of work done of DO NOT use retired | furing most of v) | | 16b. Kind of 8 | | |
| be filed tel Hygi of other | Be | 6 17. Father's Name (First, Middle, Las Willis Jeste | | near | y equipm | 18. Mother's N | | City C | | ment |
| re, Maryland s 1 end 2 should be file f Heelth end Mentel Hy item 27 ie marked oth other traumatic event | 2 | 19a Informant's Name/Relationship Robert Windsor | (Type, Print) | | g Address (Street a | and Number or | Rural Route Num | nber, City or Town | | - |
| TO Segment of Str. If or | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec | ☐Removal from State | b. Place of Dispo cemetery, cren | sition (Name of natory or other placer Mem. Pa | e) | Dete | 20c. Location Cambri | - City or To | own, State |
| Baltim permit. Pe Depertmen important: eny injury once. | | 21. Signature of Funeral Service Lice | | 22 | Name and Addres | s of Facility | Thomas F | uneral H | ome E 1613 | .A. |
| ficele be executed /Medical Examiner / Medical Examiner / Bhysicien end / Bhysicien end / Bhysicien st the buriel-trensit | dical Examiner | 23a. Part1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | one cause on each line. | sequence of): | e Hear | | | | | Approximate Interval Between Onset and Death |
| OI VILAI RECORDS, F.O. BOX 68/60, Physicien: The lew requires that the death certificate be executed ribis certificate has been signed by the attending physicien and rel director, page 2 should be deteched for use as the buriet-trensit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown | Fetal death 3 | Ectopic pregnancy Other (specify) | | | | ite of delive | ery D ay Year |
| w requires that been signed by should be dete | 6 | Part II. Other significant conditions Advance | | resulting in the un | | n in Part I. | | _ | | ne cause of death? |
| I HECOTOS, The lew requires to the lew been signed, page 2 should be on the lew been signed. | Completed | WI | | | | | 24a. We aut per 1 🗆 Yes | tormed // | Were autoprior to cordeath? | psy findings available mpletion of cause of |
| OT VITAL Physicien: 1 r this certificet | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No | Hospital: | 2 ER/Outpatien | 3 DOA Othe | _ | eath <i>(Ch</i> eck only Home 5 ☐ Re | one) sidence 6 □Oth | er (Specif) | y) |
| UNISION OT VITAI HER To the Hospitel or Attending Physicien: The lev within 24 hours efter death. To the Funaral Director: After this certificate has completely filled in by the funarel director, page 2 | Certification; | 27. Manner of Death 1 | De Diana of lainne | At home, farm, stre | | at ? ∕es 2 □ No | 28f. Location | Street and Numbown, State) | | l Route Number, |
| Mospite 24 hours Funarai | Medical C | 29a. Certifier 1 Certifying P (Check only one) 2 Madical Exa | hysician: To the best of my miner: On the basis of exan and manner stated. | knowledge, death nination and/or inv | occurred at the tim estigation, in my op | e, date and pla- inion, death oc- | ce, and due to the curred at the time | e cause(s) and ma e, date and place, | anner as st and due to | ated. the cause(s) |
| To the Within To the | Me | 29b. Signature and title of certifier | by MO | | 29c. License | | | 29d. Date signe | | Day, Year) |
| 15E) | | 30. Name and address of person who | JY 300 AU | RORA S | | DLE | MD 2 | -1613 | | |
| St Regist | ate rar | 31. Date filed (Month, Day, Year) | 32. Regitrar's S | ignature | Specific | | | | | |

| | | - | For State Registrar | State of M | Maryland / Depa <i>Ce</i> | artment of H | | | giene | 6 37753 |
|---------------------|---|---------------------|---|--|---|--|--|---|--|---|
| 2 | | 12. | Decedent's Name (First, Middle, Last, | | | · · · · · · · · · · · · · · · · · · · | | 2. Date of Dea | | 3. Time of Death |
| | Physicia /Medic | | Thelma E. Ya | ncey | | | | | r 2, 200 | 6 1:07 a ^M |
| | Examin | | 4a. Facility Name (If not institution, give | street and number | r) | | Location of Death | | 4c. County of | |
| | 3 | | 1106 - 60th Ave. | 7.4 | | Fairmon | t Height | | | e Georges Birthplace (State or Foreign |
| | Funeral | | 5. Social Security Number 6. Sec 1579-34-4654 | х]м 21 <u>С</u>] F | Age (In yrs. last birthday) 76 Yrs. | Months Days | Hours Min. | (Month, Da) | y, Year) | Country) |
| | Director | | Usual Residence of Decedent | | 70 | | | Nov. 6, | 1929 W | ashington,D.C. |
| | /land | | 10a. State 10b. County | | 10c. City, Town or L | ocation | | | | 10d. Inside City Limits |
| | Man Man | to | Maryland Prince G | eorges | Fairmon | t Heights | | | | 1 ☑ Yes 2 □ No |
| | or 28 | Jire | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of Wha | at Country? |
| | 23a | rai | 1106-60th Avenue | | | 20743 | | | United S | |
| 98 | toges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If itam 27 is marked other than "natural", or itams 23a or 28a-f ahow or other traumatic event, the Madical Examiner must be multified at | by Funeral Director | 11. Marital Status 1 Never Married 2 Married | 12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give | s? XNo | Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No | ispanic Origin? (Span, Mexican, Puerti Specify: | pecify Yes or No- o Rican, etc.) | | American Indian, White, etc. Black |
| 21215-0036 | hours tural' | q p | 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu | Year or Dates | | dent's Usual Occup | ation | | 16b. Kind of Busin | ness/Industry |
| <u> </u> | n 72 n "na | Completed | (Specify only highest grad | le completed) | (Give | kind of work done of DO NOT use retired | during most of wor | king | TOD. TRING OF BOOM | io da in dadity |
| 12 | with lene. than | mo di | Elementary/Secondary (0-12) | College (1-4o | | usewife | | | Domest | tic |
| D | Hyg othe | BeC | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nan | ne (First, Middle, | Maiden Sumame) | |
| lar | Aenta Aenta rked tlc ev | To B | Richard Moore | | | | Olga Y | ates | | |
| any | and h | | 19a. Informant's Name/Relationship (T) | rpe, Print) | | ing Address (Street | | | | ate, Zip Code) |
| Σ | is 1 and 2. If Health air (tam 27 ls.) | | 01ga Cooks / Dau | ghter | | -60th Ave | . Fairmo | 1000 1000 | | 20743 |
| ore | Jes 1 | | 20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ I | Removal from Stat | | matory or other place | | Date | 20c. Location · Ci | |
| Ē | . Pag tment tant: | | 4 □ Donation 5 □ Other (Specify, | 1-1 | | Memorial | | 9,2006 | Landove | r, Ma. |
| Baltimore, Maryland | permit. Pages 1 and Department of Heal Important: If Itam 2 any injury or other 2009. | | 21. Signatur Funeral Service Licens | Leve s | M01085 | 2. Name and Address Alexander 5538 Mari | boro Pope | Funeral e/Forest | Homes, M | |
| | | | 23a. Parti. Enter the disease, or comp shock, or heart failure. List only of | lications that caus ne cause on each | sed the death. Do not en i line. | ter the mode of dyin | ng, such as cardiad | or respiratory ar | rrest, | Approximate Interval Between Onset and Death |
| | Physician | | Immediate Cause (Final disease or condition | a. (1 | ANCER | COLO | N | | | Silver and Double |
| 10.00 | /Medical Examiner | | resulting in death) | | as a consequence of): | | | | | 160 . 5 |
| 1 | LXailliller | | Sequentially list conditions, | D | ALZIEHW as a consequence of): | IERS | | | | 10922 |
| 7/4 | ed sit | lne | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury | D09 t0 (01 8 | as a consequence or). | | | | | |
| | be executed ician and burial-transit | Examine | that initiated events resulting in death) Last | c Due to (or a | as a consequence of): | | | | | |
| 8760, | ate be executed hysician and the burial-transit | ical E | l | d | | | | | | |
| 9 | ificate g phys as the | edic | | | | | | | | |
| Box | eath certific attending pl | Z | 23b. Was decedent pregnant | 23c. If yes, outcom | | □Ectopic pregnancy | , | | 23d. Date of | · · |
| | e deat he atte | Physician/Med | in the past 12 months? 1 Yes 2 No | | at time of death 5 | Other (specify) | | | Month | n Day Year |
| P.0 | at the de | Phy | 9 Unknown | | | | - in Post I | 22o Did t | obacco uso contrib | ute to the cause of death? |
| Vital Records, | law requires that the death certificate as been signed by the attending physics should be detached for use as the | ٥ | Part II. Other significant conditions co | nthouting to deatr | n but not resulting in the | undenying cause giv | en in Part I. | 1 🗆 ' | | ☐ Probably 4 ☐Unknown |
| 000 | aw re | Completed | | | | | | 24a. Was | an 24b. We | ore autopsy findings available or to completion of cause of |
| m. | The ste h | E | | | | | | perfo | rmed? _ dea | ath?]Yes 2□ No |
| ita | ician: certifice rector, p | Be C | 25. Was case referred to medical examiner? | | | | 26. Place of Dea | ath (Check only o | one) | |
| of < | Physician: this certific ral director. | 2 | 1 ☐ Yes 2 ☐ No | Hospital: 1 ☐ Inpa | | HIL SU DOA | | | dence 6 Other | |
| ח | ding P. h. After t funera | ë. | 27. Manyer of Death 1 V Natural 5 ☐ Pending | 28a. Date of It (Month, I | njury 28b. Time Day Year) Injury | Wor | | 28d. Describe | how injury occurred | |
| Sio | Attending ir death. ector: After by the fune | cat | 2 Accident investigation 3 Suicide 6 Could not be | 30a Blace of | Injury - At home, farm, s | | Yes 2 □No | 28f Location (| Street and Number | or Rural Route Number, |
| Division | or At after o Direct in by | Certification: | 4 Homicide determined | | etc. (Specify) | riest, factory, office | | City or To | | |
| _ | To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the | edical C | 29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam | ysician: To the be iner: On the basis and manner | est of my knowledge, dea s of examination and/or i | ith occurred at the tir nvestigation, in my c | me, date and place opinion, death occu | e, and due to the urred at the time, | cause(s) and mann date and place, and | ner as stated. d due to the cause(s) |
| | within 2 To the | Med | 29b. Signature and title of certifier | and manner | | 29c. Licens | se number | | 29d. Date signed (| Month, Day, Year) |
| \ | ⊢ ≯ ⊢ ŏ | | Nena | MD | | Do | 00509 | 51 | 11/8 | 106 |
| 1 | (1) | | 30. Name and address of person who | completed cause of | of death (Item 23a) (Type | | | , | 1 | |
| 1 | -(0) | | REVA . S. GIL | L 651 | O KENIL | WORTH | AVE P | 21 VERA | ALE JAI | 0 20737 |
| | St Regist | ate rar | 31. Date filed (Month, Day, Year) NOV 1 3 2006 | Dereux | istrar's Signature | 5 | | | | |

DHMH 17 Rev 1/2001

Registrar

| | | | | For State | State of M | | d / Depa | artmer | nt of H | lealth and | | | | 006 | 37 | 155 |
|---------|---------------------|---|-----------------------------|--|--|----------------------------|----------------------------|--------------------------|------------------------|---|---------------------|---|------------|----------------------------|---------------------------------------|-------------------------|
| | | | | Registrar | | | Cei | rtificat | re or | Death | O Dat | Reg te of Death | . No. | | 3 Time o | Dooth |
| | | Physici /Medio | | 1. Decedent's Name (First, Middle, Las JoAnne P. Ar | - | | | | | | Mg | | 2ª4 | 2წწ6 | 3. Time of 4:2 | 7 PM |
| | Y | Examin | er | 4a. Facility Name (If not institution, give | | | | | | r Location of Dea | th | | | unty of Death | , | |
| | | | | Upper Chesapeal 5. Social Security Number 6. S | ce Medic | al C | enter | If Unde | Bel | Air | B. B Dat | e of Birth | | Harfo | | or Foreian |
| | | Funeral Director | | 216-24-6867 | _ M 2CXF | | 77 Yrs. | Months | | Hours Min | 4/ | e of Birth onth, Day, Y 3 0 / 1 9 | 29_ | Mar | lace (State of try) yland | l |
| | | pu k | | Usual Residence of Decedent 10a. State 10b. County | | 10c. Cit | ty, Town or Lo | cation | | | | | | 1 | 0d. Inside C | ity Limits |
| | | Maryla -f aho | tor | MD Harfor | rđ | | Abing | | | | | | | | 1 🗆 Yes | ×⊠No |
| | | death with the Marylar ems 23a or 28a-f ahow at must be coulded at | Funeral Director | 10e. Street and Number 203 B Oak | Leaf Ct. | | • | 10f. Zi | p Code 2 | 1009 | | 109 | . Citizen | of What Cour USA | try? | |
| 2 | | ms 23 | era | 11. Marital Status | 12. Was Deceden | t Ever in U | .S. 13. | Was Dece | dent of H | tispanic Origin? (i an, Mexican, Pue | Specify Ye | es or No- | 14. | Race - Americ | | |
| 26.5 | 36 | within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ahow ha Madisal Examiner musi be notified al | þ | 1 Never Married 2 Married 3 Widowed 4 Divorced | Amed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates | No | | | | Specify: | no nican, | eic.) | Sp | Black, White, pecify: W. | hite | |
| | 2-0 | "natura | sted | 15. Decedent's Ed (Specify only highest gra | fucation de completed) | | 16a. Dece | dent's Usu | ual Occup | oation during most of wo d) | orking | 10 | Sb. Kind | of Business/Inc | lustry | |
| 0 | 121 | be filed within 72 hatal Hygiene. Id other than "natu avant, the Medical | Completed | Elementary/Secondary (0-12) | College (1-4or | 5+) | | ales | | | J | | Rea | al Est | ate | |
| 1/24/06 | d 2 | filed Hygir other | Be Co | 17. Father's Name (First, Middle, Last) | | | | | | 18. Mother's Na | ıme (First, | Middle, Ma | aiden Su | тате) | | |
| 7 | <u>a</u> | Mental Mental rked | To B | Charles Bl | ackburn | | | | | Marg | guar. | ite E | larv | <i>т</i> еу | | |
| - | Maryland 21215-0036 | s 1 end 2 should be filed within f Health and Mental Hygiene. Item 27 Ia marked other than othar traumatic avant, tha Ms | | 19a. Informant's Name/Relationship (Pamela Foley | | er | 19b. Maili 172 | ng Addres | s (Street Leas | and Number or F | lural Route Le R | d. Fo | ores | own, State, Zip st Hil | Code) 1 MI 2105(| |
| | | permit. Pages 1 end 2 Department of Health a Important: If item 27 li any injury or other tra once. | | 20a. Method of Disposition 1 □ Burial 2 【2 Cremation 3 □ | | 120h F | Place of Disponentery, cre | osition (Na matory or | ame of other pla | ce) No | Date vemb | er | | tion - City or To | wn, State | |
| | Baltimore, | artment artment ortant: injury c | | 4 Donation 5 Other (Specifical Signature of Funeral Service Licer | y) | Ċ'na | ins Fu pel - | | | | , 20 | - | 3 1 | rest H Tewpor | t Dr. | |
| 0 | Ba | Per Per Per Per Per Per Per Per Per Per | | la la Je | Low | | £Y. | id ⁿ S | rema | ieral Cl | ervi | ces 1 | fore | est Hi | 21058 | 4D |
| 536 | | Physician | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final | plications that cause one cause on each | ed the dear line. | th. Do not en | ter the mo | de of dyir | ng, such as cardia | ac or respi | ratory arres | it, | | Approxima Interval Be Onset and | tween |
| ut | 1 | /Medical Examiner | | disease or condition resulting in death) | Due to (or a | s a consec | quence of): | run | _ | / | | | | | | |
| 8001 | | | Je | Sequentially list conditions, if any, leading to immediate | b. Due to (or a | s a consec | quence of): | 4 | on | <u></u> | | | | | | |
| 30 | | te be executed ysicien and to burial-transit | Examiner | Sequentially list conditions, if any, teacing to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or a | s a conse | quence of): | | | | | | | - | | |
| 5 | 760, | ie be ey ysicien e buria | calE | | d | | | | | | | | | | | |
| 10 | 68 | nificate ng phys as the | | | V | | | | | | - | | | 1 | | |
| NHO | O. Box | ne death ce the attendii hed for use | Completed by Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 25 No 9 ☐ Unknown | 23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown | 2 ☐ Feta at time of a | al death 3 | ⊒Ectopic ⊒ Other (s | | у | | | 230 | d. Date of delive Month | ory Day | Year |
| 18 | s, P. | es thet thighed by be detact | by Ph | Part II. Dther significant conditions | contributing to death | but not re | sulting in the u | underlying | cause gr | ven in Part I. | 2: | | | contribute to t | | |
| - | ord | v require been si should I | ted | Colon cere | | | | | | | | | 2 🗆 1 | | | Unknown |
| 6 | Record | The law | ompie | conony | ulung | dise | · cas | , | _ | | | 4a. Was an autopsy perform ☐ Yes 2 | 1 | death? | psy findings mpletion of 2 No | s available cause of |
| + | Vital | ician: Th certificate rector, pag | Be | 25. Was case referred to medical examiner? | | | | | | 26. Place of D | eath (Che | ck only one |) | | | |
| 6 | of V | Physician: this certifice ral director, p | 2 | 1 ☐ Yes 2 No | Hospital: 1'Ninpa | | ER/Outpatie | | JUA | | | Resider | | Other (Special | y) | |
| And | | Attending F ir death. ector: After by the funer | tion | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation | 28a. Date of In (Month, I | Day Year) | Injury | м | 28c, Inju Wo 1 [| ork?]Yes 2∐No | 200. 0 | 03011001101 | v injury c | , ocu | | |
| 4 | Division | pital or Attending Physician: The law requires ours after death. Interest of the second free of the second free of the second filled in by the funeral director, page 2 should be | Certification: | 3 Suicide 6 Could not be determined | 289. Place of t | njury - At h etc. (Spec | nome, farm, st ify) | treet, facto | ory, office | | | ocation (Str ity or Town, | | Number or Aur | il Route Nu | mber, |
| | | Hos Fun Jely | edical C | | hysician: To the be miner: On the basis and manner | of examin | | | | | | | | | | (s) |
| | | To the Hos within 24 h To the Fur completely | Me | 29b. Signature and title of certifier | | | | 2 | 9c. Licen | se number | - | 29 | d. Date s | signed (Month, | Day, Year) | |
| | | 4 | | Daved 5 | Dun | | | | Ø. | 3 2 29 | 9 | 8 | Voe | lu 25 | ,20 | 0 (|
| | | 10 | | 30. Name and address of person who | | | | | | | | | | | | |
| | | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | 31. Date filed (Month, Day, Year) | | strar's Sign | Mac | rha. | .] | Be/ 3 | (,, | 90 | | | | |
| | | St Regist | ate | NOV 2 9 2 | 006 | 1 | V 14 | 13-54-V | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** MARY 7:00 AM NOVEMBER 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** VIRGINIA ESSEX AUC If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours 231-72-320 Yrs. Director Usual Residence of Decedent 10b County 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28e-f show Examiner must be notified at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S. +1 21221 or Items 23a Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired). other traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 1.2 should be filed within 7. In and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) HOME HOUSEWIFE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Heath and Mental Important: If Item 27 is marked i any injury or other traumatic ave SIMPSON ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARROW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) City or Town, State ■Burial 2 Cremation 3 Removal from State NORFOLK ALVARY * 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee UnerAL Home Approximate Interval Between Onset and Death Sollers Pel 7110 23a. Pari 1. Enter the disease, or complications that caused the death. Do not have the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA 10 YEARS /Medical Due to (or as a consequence of) Examiner STROKE MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fur as a consequence of Examiner burial-transit Division of Vital Records, P.O. Box 68760, FIBRILLATION ATRIAL attending physician and Due to (or as a consequence of) Completed by Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown LEDIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 2 No 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 Yes 2 No 4 Nursing Home 5 PResidence 6 Other (Specify) To the Funeral Diractor: After thi completely filled in by the funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOVEMBER 27 D62032 2006 30. Na e an address of person who completed ause of death (Item 23a) (Type, Print) HAYASHL. 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE egistrar's Signature 31. Date filed (Month, Day, Year) 32. State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Aydelotte Abey

Baltimore, Maryland 21215-0036

| | | | For State Registrar | State of | Marylan | | artment of rtificate of | | | _ | giene Reg. No. | 006 | 37757 |
|---------------------|---|----------------|--|---|--|----------------------|---|------------------------|----------------|-----------------------------------|-------------------|--------------------------|--|
| 4. | Physicia /Medic | _ | 1. Decedent's Name (First, Middle, | Aydelot | te Loi | rraine | Abey | | | 2. Date of De Month Vovembe | Day | Year 2006 | 3. Time of Death 12:52 P.M |
| | Examin | | 4a. Facility Name (If not institution, | | | ^ | 4b. City, Town, | _ | | | | ounty of Deat | |
| 1 | 3 - 4 - 1 | * | Baltimore Wash | | dical (| | Glen If Under 1 Yea | | | 8. Date of Birt | | ne Arı | indel hplace (State or Foreign |
| | Funeral Director | | 214 30 3879 | 1 M 2 M F | 74 | Yrs. | Months Day | | s Min. | Month, Da | y, Year) | Co | ryland |
| | | | Usual Residence of Decedent | | | | | | 1 1 | NOV. I | , 1772 | - Hai | |
| | irylan show i at | | 10a. State 10b. County | | | y, Town or Lo | | | | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No |
| | ne Ma 8a-f s ptiffec | Director | | Arundel | ŀ | ernda. | _ | | | | | | |
| | with the | Ë | 10e. Street and Number | | | | 10f. Zip Code | | | | | n of What Co •S • | untry? |
| | eath ns 23 must | Funeral | 109 Oak Avenu | 12, Was Decede | ent Ever in U. | S. 13. | Was Decedent of If Yes, specify Cu | LO61 Hispanic | Origin? (Spec | cify Yes or No | | . Race - Ame | rican Indian, |
| 980 | filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at | | 1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced | Armed Force d 1 ☐ Yes 2 If Yes, Give Year or Date | X No | | If Yes, specify Cu 1 ☐ Yes 2[x] N | | | lican, etc.) | | Black, White pecify: Wh | |
| 2-0 | 72 hou natura lical E | ed | 15. Decedent's (Specify only highest | Education grade completed) | | 16a. Dece | dent's Usual Occ | upation ne during m | nost of workin | a a | 16b. Kind | of Business/ | Industry |
| Maryland 21215-0036 | ges 1 and 2 should be filed within 72 ho th Chaith and Mental Hygiene. If ich E71 is marked other than "natuu or other traumatic event, the Medical. | Completed by | Elementary/Secondary (0-12) 12th | College (1-4 | or 5+) | | kind of work don DO NOT use reti emaker | red) | | 3 | (| Own Ho | me |
| d 2 | filed Hygi other ent, tl | Be C | 17. Father's Name (First, Middle, La | 1 ast) | | L | | 18. Mc | other's Name | (First, Middle, | Maiden Su | ırname) | |
| /lan | uld be Menta Irked tric ev | To B | Free | d Meister, | Sr. | | | | Lilli | an Lot | sey | | |
| lar) | 2 sho and I is ma | ľ | 19a. Informant's Name/Relationshi | | 4 | | ng Address (Stre | | | | | | • ' |
| 2 | 1 and 2 Health em 27 i | | Donald Abey, S | r. / Husba | | | oak Aven | | | ale, M | | nd 210 tion - City or | |
| JOE | iges 1 nt of F iffite or ot | | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation | | | | osition (Name of matory or other p | | 1 | | | • | e, Maryland |
| Baltimore, | it. Pa irtmer irtant: njury | | 4 ☐ Donation 5 ☐ Other (Special Signature 4 ☐ Other (Special Signature 4 ☐ Other (Special Signature 4 ☐ Other (Special Signature 4 ☐ Other (Special Signature 4 ☐ Other (Special Signature 4 ☐ Other | | _ G1e | en Hav | en Mem. 2. Name and Add | Park tress of Fa | i II/Z/ | / 2006 nac Fu | | | ce, P.A. |
| Ba | permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once. | |) MAHZ | | | | | | | | | | yland 21225 |
| | 3 | | 23a. Part1. Enter the disease, or c shock, or heart failure. List o | omplications that cau | sed the deat | | | | | | | | Approximate Interval Between |
| 1 | Physician | | Immediate Cause (Final disease or condition | a Run | hard | Y | vertien | 29215 | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | ue to (| as a conse | uence of): | | | | | | | |
| 58 | | Į. | Sequentially list conditions, | b. Due t | as Lonseq | uence of): | - | | | | | | |
| | uted ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | | |
| ó | be executed ician and burial-transit | Еха | resulting in death) Last | Due to (or | as a conseq | uence of): | | | | | | | |
| 8760, | cate be executed physician and the burial-transit | dical | ' | d | <u> </u> | | | | | | | | |
| 9 | certific ding p | /Mec | IF FEMALE: | 23c. If yes, outco | me of oregon | ancy | | 1.0000000 | | | 000 | d Data of da | livon. |
| Box | death certifica attending ph for use as the | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | 1 ☐ Live bir | th 2 Feta | al death 3 | ⊒Ectopic pregnai ⊒ Other (specify) | | | | 23 | d. Date of de Month | Day Year |
| P.O. | the d | hysi | 1 ☐ Yes 2 🗹 No 9 ☐ Unknown | 9□Unknov | | | | | | | | | |
| or Vital Records, P | The law requires that the death certificate be executed the has been signed by the attending physician and sage 2 should be detached for use as the burial-transit | þ | Part II. Other significant condition | ns contributing to dea | th but not res | ulting in the t | inderlying cause | given in Pa | art I. | 23e. Did t | | | o the cause of death? robabły 4 □Unknown |
| 900 | law re as bee 2 sho | Completed | | | | | | | | 24a. Was | psy | prior to | utopsy findings available completion of cause of |
| R | The cate h | Com | | | | | | | | perfo 1⊟ Yes | 2 No | death? | 2 □ No |
| Vita | Physician: r this certific ral director, | Be | 25. Was case referred to medical examiner? | Hospital: | | | | ther: | | (Check only o | | | |
| 0 | Phys | . To | 1 ☐ Yes 2 ☑ No 27. Manner of Death | 28a. Date of | | ER/Outpatie | III JUDOA | 4 🗆 | | ne 5 🗆 Resi 28d. Describe | | | cify) |
| 0 | Attending r death. ector: After sy the funer | tion | 1 Natural 5 Pending 2 Accident investiga | (Month | , Day Year) | Injury | of 28c. Ir W M 1 | /ork? □ Yes 2 | | | , , | | |
| Division | | Certification: | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin | Zoe. Place u | f injury - At ho g, etc. <i>(Specii</i> | ome, farm, st fy) | reet, factory, office | æ | 2 | .8f. Location (City or To | Street and i | Number or R | ural Route Number, |
| D | urs aft eral Di | Cer | On Online Description | Physician: To the b | and of my lens | nuladas dos | th cooursed at the | time date | a and place of | and due to the | 001150/5/ 0 | nd mannar a | e etatod |
| | To the Hospital or within 24 hours afte To the Funeral Dit completely filled in | Medical | 29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical E | xaminer: On the bas and manne | sis of examina | ation and/or i | nvestigation, in m | y opinion, | death occurre | ed at the time, | date and p | place, and du | e to the cause(s) |
| | To th withir To th | Me | 29b. Signature and title of certifier | | | 01 | 29c. Lice | ense numb | er | | 29d. Date | signed (Mon | th, Day, Year) |
| | | | YEONG | 04 | 1 | MI | - 4 | 250 | 654 | | (1) | 124/0 | 6 |
| | 10 | | 30. Name and address of person v | | | | | | p | 64-0 | | -7 | (1 |
| - 00 | , Ct | ate | 31. Date filed (Month, Day, Year) | 32. | Cyngistrar's Signa | ature | 10 | 671 | > | MD | | 6101 | 2 |
| | Regist | | NOV 2 9 | 2006 | SULL . | B. A | never ! | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | State of Maryland / Department of State of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Certific | of Health and M of Death | | ene 006 | 3775 | 8 |
|-------------------------------------|--|----------------|--|--|---------------------------------------|---------------------------------------|--|-----------|
| | Physici | | 1. Decedent's Name (First, Middle, Last) George Victor Anderson, Jr. | | 2. Date of Death Month NOVEMBER | Day Year | 3. Time of Deat | th A M |
| | /Medic Examin | | | wn, or Location of Death | NOVERIDER | 4c. County of Dea | | 7 |
| | ZAGIIIII | | GREATER BALTIMORE MEDICAL CENTER TOW | SON | | BALTIMO | ORE | |
| | Funeral Director | | 022-16-6786 A Yrs. | 'ear If Under 24 Hrs. ays Hours Min. | 8. Date of Birth May 17, | 1924 Mass | thplace (State or Fore ountry) achusetts | eign |
| | and | | Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location | | | | 10d. Inside City Lin | nits |
| > | death with the Maryland ms 23a or 28a-f ehow rmast be notified at | ō | Md. Baltimore Timonium | | | | 1 □ Yes 2 🖔 | |
| M | 288- | Director | 10e. Street and Number 10f. Zip Co | de | 10 | g. Citizen of What Co | ountry? | |
| P | h with | | 119 Castletown Road #302 | 21093 | | USA | | |
| CONG B | deat | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent If Yes, specify | t of Hispanic Origin? (Spe Cuban, Mexican, Puerto | ecify Yes or No- | 14. Race - Ame Black, Whit | | |
| J. (J. C. | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiane. Important: If item 27 is marked other then "netural", or items 23a or 28a-f ehow eny injury or other traumatic event, it a Medical Exarcinar must be notified at once. | م ا | 1 Never Married 2XXXMarried 1XX Yes 2 No | No Specify: | ritodri, oto., | 0 | hite | |
| 5-0 | 72 h | Completed | 15. Decedent's Education 16a. Decedent's Usual O. (Specify only highest grade completed) (Give kind of work di | ccupation lone during most of workii etired) | ng 1 | 6b. Kind of Business | Industry | |
| SON 21215 | within the the the the the the the the the the | d d | Elementary/Secondary (0-12) College (1-4or 5+) 5+ Business C | | | plicator | 20162 | Τn |
| | Hygis Hygis ther ont, tt | | 17. Father's Name (First, Middle, Last) | 18. Mother's Name | | · | sales co. | 1111 |
| Inder R Maryland | ld be ental ked o | To Be | George V. Anderson, Sr. | | | ddinaton | | |
| 3 Z | should and Mer s marks umatic | - | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (St. | | | | Zip Code) | |
| - | and 2 Balth a n 27 Is | | Mrs. Mary E. Anderson/Wife 119 Castleto | own Rd. #302 | Timoniu | m, Maryla | nd 21093 | |
| ∤ Baltimore | Pages 1 and of He ut: If Item | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State | r place) | | Oc. Location - City or | | |
| Ē | Pag tment tant: | | 4 □Donation 5 □Other (Specify) Dulaney Valley N | | | | • | |
| Bal | permit Depar Impor eny in | | | ddress of Facility Ruc k Road Tow | | | | • |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. | f dying, such as cardiac o | r respiratory arres | st, | Approximate Interval Between | |
| | Physician | | Immediate Cause (Final disease or condition | failer | | | Onset and Death | 1 |
| | /Medical Examiner | | resulting in death) Due to (or as consequence of): | failer Luresuls | 1 | | <u></u> | |
| | | -e | | reluxerule | n des | 2011 |) lely | |
| | uted 3 ansit | Examiner | cause. Enter Underlying Cause (Disease or injury | | | | | |
| o, | s be executed sicien and burial-transit | | that initiated events resulting in death) Last C. Due to (or as a consequence of): | | | | | |
| 8760, | cate be executed physicien and the burial-transit | dical | d | <u> v</u> | | | | |
| 9 | ing ph | Med | IF FEMALE: | | | | | |
| ã | ath ce ttendi or use | an/ | 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregn | | | 23d. Date of del Month | ivery Day Year | |
| Division of Vital Records, P.O. Box | that the death certific ed by the attending p detached for use as | Physician/Me | 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify 9 ☐ Unknown 9 ☐ Unknown | ý) | | , , , , , , , , , , , , , , , , , , , | buy rour | |
| مز | that the ded by | P. | Part II. Dther significant conditions contributing to death but not resulting in the underlying cause | e given in Part I. | 23e. Did toba | acco use contribute to | the cause of death? | ? |
| ds | quires tha n signed uld be del | Completed by | Atreal fibrillate, 18 yponationer |) | 1 ☐ Yes | 2 □ No 3 □ Pr | obably 4 Junkno | own |
| <u> </u> | s been si should | jete | 01 | | 24a. Was an | 24b. Were au | topsy findings availa | able |
| Re | The law te has age 2 : | E O | | | autopsy | ed? prior to death? | completion of cause | of |
| ital | an: rtifica stor, p | 0 | 25. Was case referred to medical | 26. Place of Death | | V No 1 | 2 L NO | |
| <u>></u> | nysici nis cel direc | To B | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other | | ce 6 □Other (Spe | city) | |
| 0 [| ng Pt fter th meral | | 27. Manner of Death 1921 Natural 28a. Date of Injury 28b. Time of 1921 Natural 28c. Injury 28c. | Injury at 2 Work? | 8d. Describe how | injury occurred | | |
| sio | tendi eath. or: A the fu | cati | | 1 ☐ Yes 2 ☐ No | | | | |
| .≅ | or Att | Certification: | 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify) | fice 2 | 28f. Location (Stre City or Town, | et and Number or Ru State) | ıral Route Number, | |
| | pital ours a erai (| | 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the | no time, data and place. | and due to the ear | uno(n) and minara | | |
| | To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as | edical | 29a. Certifier (Check only one) Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the control of the basis of examination and/or investigation, in and manner stated. | my opinion, death occurre | ed at the time, dat | e and place, and due | to the cause(s) | |
| | ro the within ro the complex c | Me | ^ | cense number | 290 | d. Date signed (Monti | n, Day, Year) | |
| | ,,,,,,, | | Donaly Wylee D' | 26394 | 1 | 1/27/06 | | |
| 14 | 4+15 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OWALL) T, WEG LEIN 6569 N, CH | ARLES ST | #411 | BALTU | 21204 | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 2. 9 2006 32. Registrar's Signature | | | | | |

| | | For Stata Registrar | | State of | Maryla | nd / Dep <i>Ce</i> | oartmer e <i>rtificat</i> | nt of He re of D | ealth and Death | i Mental Hy | giene (| 006 | 377 | 59 |
|--|------------------|--|---------------------------------|---|--|------------------------------------|------------------------------|---------------------------------|---|--|---------------------------------|--------------------------------|--|-----------------|
| Physicia /Medic | | 1. Decedent's Name (F | irst, Middle, Las | grve | -2 | | | | | 2. Date of De | Day | ZOOC | 3. Time of De | |
| Examine | er | 4a. Facility Name (If not | 1 Ho | STIM | i | | 5 | 40 | L | NE | | | /A | |
| Funeral Director | | 5. Social Security Number 212-32-74 Usual Residence of December 212-32-74 | 140 | x □_xw 2□ F | 7. Age (In yrs | 70 Yrs. | Months | Days | Hours Mi | in. (Month, Da | th ly, Year) 1, 1936 | Cour | place (State or F ntry) Maryland | Foreign |
| Maryland a-f ehow | tor | 10a. State 10 Maryland | b. County | I/A | 10c. C | ity, Town or | Location | Ва | ltimore | | | 1 | 0d. Inside City | |
| th with the 23a or 28 Ist be not | Funeral Director | 10e. Street and Number 318 North C | | enue | | | 10f. Zip | Code | 21223 | | 10g. Citizen | of What Cour | , | |
| ite; INIGITY INITION AT INITIONS AND A STANDARD A STAND | y Funer | 11. Marital Status | | 12. Was Dece Armed For 1 Dyes If Yes, Give | ces? 2 ∐ No | J.S. 13 | Was Dece If Yes, spe | | panic Origin? , Mexican, Pue Specify: | (Specify Yes or No erto Rican, etc.) | | lace - Americ lack, White, | etc. | |
| 72 hours "natural", | eted by | | Divorced Decedent's Edu | Year or Da | | (Giv | edent's Usu | al Occupati | | vorking | Spe | Business/Inc | Black | |
| yidilid Kik buld be filed within Mental Hygiene. arked other than atic event, the Ma | Completed | Elementary/Secondar 12 17. Father's Name (Firs | | College (1- | 4or 5+) | ///e. | Mo Mo | tor Veh | icle Opera | ator ame (First, Middle, | | | arnson For | t |
| hould be do Mental marked o | To Be | 19a. Informant's Name | William | Barnes | | 19h Mai | ling Address | | | | yrtle Barr | nes | 0-1-1 | |
| C, INIC | 9 | Doris M. Barr 20a. Method of Disposit | nes Wife | | 20b. | Place of Disa | 318 Nor | th Carro | ollton Aver | nue Baltimore | , Marylan | | | |
| Page nent of any or | | 1 Mourial 2 Co | Other (Specify) | == | tate | 0.00 | - | eterans | Cemetery | 12/05/06 | | Owings M | | |
| permit. Departri Importe eny inju | | 23a, Part I, Enter the d | U) | ications that ca | USed the dea | PR | E 1 | step Br | others Fu | neral Service Baltimore, M | d 21217 | | Approximate | |
| Physician /Medical | | shock, or heart fai Immediate Cause (Fina disease or condition resulting in death) | ilure. List only o | a. Ch | ch line. | 035 | | | | Disea | | | Onset and Dea | |
| Examiner | ler | Sequentially list conditi- if any, leading to immed | ons, diate | b | r as a conse | | | | | | | | | |
| cate be executed physicien and the burial-transit | Examin | cause. Enter Underlyin Cause (Disease or injur that initiated events resulting in death) Last | ý 1 | Due to (c | r as a conse | quence of): | | | | | | | | |
| rificate being physici | Medicai | IF FORM C | • | d | | | | | | | | | | |
| The law requires that the death certificate has been signed by the attending page 2 should be detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | nths? | | th 2 ☐ Fet nt at time of | al death 3 | □Ectopic pr □ Other (sp | | | | | Date of delive Month | ry Day Yea | ir |
| w requires that been signed be determined by the should be | ò | Part II. Other significan | . > _ 1 | ntributing to dea | ath but not re | sulting in the | underlying c | | in Part I. | | obacco use co ⁄es 2 □ No | ntribute to th | e cause of deat | / |
| ysician: The law ro is certificate has be director, page 2 sh | Completed | | | | | | | | | | an 24t sy rmed? 2 1 No | death? | osy findings ava npletion of caus 2 No | ulable se of |
| ng Ph fter th | ation: To Be | 25. Was case referred texaminer? 1 Yes 2 No 27. Manne of Death 1 Natural 5 2 Accident | | 28a. Date of | | ER/Outpatie 28b. Time Injury | | Other: 8c. Injury a Work? | 4 🗆 Nursing | eath Check on on one one one one one one one one o | lence 6 🗆 C | |) | |
| al or Attences after death | Certification: | | Could not be determined | 28e. Place of building | f Injury - At h g, etc. <i>(Speci</i> | ome, farm, s | treet, factory | r, office | | 28f. Location (S City or Tox | Street and Nur m, State) | nber or Rura | Route Number | Γ, |
| To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu | edical | 29a. Certifier 1 9 (Check only 2) one) | Certifying Phy Medical Exami | sician: To the b ner: On the bas and manne | us of examina | owledge, dea ation and/or i | th occurred nvestigation | at the time, in my opin | , date and place nion, death occ | ce, and due to the courred at the time, | cause(s) and r | manner as sta e, and due to | ated. the cause(s) | |
| Tot Common | Σ | 29b. Signature and title | of certifier | ,5tA, | NO | | 290 | License r | LC 3 | 34 | 29d. Date sign | | | ? |
| 3 | | 30. Name and address | Cost | mpleted cause | 30 | 73 10 | Print) | UL F | AU | = BA | TVI | RE | 10 21 | 1202 |
| State Registra | | 31. Date filed (Month, D | OV 9 0 | | trar's Sign | ature | Cost | 9 | | | | | | |

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Vear Raymond Lyle Banton, Sr. 8:20 A.M November 27 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Hammonds Lane Baltimore Anne Arundel | Hous | Hous | Min. | B. Date of Birth (Month, Day, Year) | April 10,1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 ☐ F 214 20 6177 80 Director West Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or iteme 23a or 28a-f ehow the Medical Examiner must be notified at Maryland Anne Arundel 1 ☐ Yes 2 X No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Hammonds Lane U.S. 21225 death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 SaYes 2 No If Yes, Give WW II Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "na eny Injury or other traumatic event, the Wadto once. Elementary/Secondary (0-12) 8th College (1-4or 5+) Painter Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Banton Lena Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Hammonds Lane Baltimore, Maryland 21225 Sophie Banton / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation Si □ Other (Specify) MD. State Veteran Cem. 12/01/2006 Crownsville, Maryland 21. Sign in a ci Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enfer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRUCTION **Physician** INTESTINAL /Medical Due to (or as a consequence of): Examiner YEARS METASTATIC COLON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physicien Box 68760 Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DEMENTIA 1 ☐ Yes 2 ☐ No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2□ No 1 Yes 2 - No 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 No 2 ER/Outpatient 3 DOA this I Director: After the in by the funera 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours after To the Funeral Dire Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D29807 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARLOS D. ZIGER SUITE 106. 1408 S. CRAIN HWY GEN BURNIE MD 2106/ 31. Date filed (Month, Day, Year) 32. Degistrar's Signature Registrar

Please Type or Print in Black Indelible Ink

William J. Barnes, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day November 22, 2006 **Medical Examiner** William John Barnes, Jr. 1324 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 525 East Patapsco Avenue Apt A Baltimore N/A 5. Social Security Number **Funeral** 6 Sex Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Director Davs 218 84 0002 Hours 30 1 X M D4/06/1976 Country) Maryland Usual Residence of Decedent any 10b. County Oc. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. 28a-f show Maryland Anne Arundel Baltimore 1 Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 322 Panorama Way 21225 U.S. Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 1 X Never Married Armed Forces White, etc 2 X No Yes 3 Widowed Specify: White 4 Divorced If Yes, Give Year Yes 2X No specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Roofer Construction 10th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William John Barnes, Sr. Carolyn Musgrove ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William J. Barnes, Sr./ Father 322 Panorama Way Baltimore, Maryland 21225 20a Method of Disposition Baltimore, 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Cedar Hill Cemeterv 11/28/2006 Baltimore, Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility Gonce Funeral Service, P.A. Signature of Funeral Service Licensee Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part I. Enter the diseas **Physician** Approximate Interval /Medical Narcotic (methadone and morphine) and cocaine intoxication Immediate Cause (Final disease Death Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical the attending physician ed for use as the bunal XUNPENDED AMENDED #23a,27,28a-f 12/8/06 TI perME. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? 2 Month Year Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 2 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Pending 1 Yes 2 No Fnd 11/22/2000 Fnd 12:30 Accident unknown Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 525 E. Patapsco Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be determined (Specify) 4 Homicide found at home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical within 2 To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E November 23, 2006 rson who completed squise of death (Item 23a) Jack Titus MD. U Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Red State Registra

| | | 1 - For State Registrar 1. Decedent's Name (First, Mide | | - | | | | | | 2. Date of Dea | | | 0 T ' |
|--|---|---|--|--|--|--|---|--|---|--|--|--|--|
| hysici | | ARLENE | | BLACK | (I) N | S | | | | Month | Day | Year | 100 |
| /Medio Examir | | 4a. Facility Name (If not institution | | | - 21 - 1 | | . Town, or | Location | of Death | | 4c. C | <u>2から</u> county of De | |
| | | M | lanor Care | Health Sen | vices | | | | Baltin | nore | | | ltimore |
| uneral | | 5. Social Security Number | 6. Sex | | n yrs. last birth | hday) If Unde Months | r 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Birt (Month, Day | h (Year) | 9. B | irthplace (State of |
| rector | | 214-76-5485 | 1 □ M 2√ | (JF) | 66 Y | rs. | Days | Tiours | 191311. | Nov 10 | | | Maryland |
| A C | | Usual Residence of Decedent 10a. State 10b. Count | ty | 10 | Oc. City, Town | or Location | | | | | | | 10d. Inside Cit |
| f sho | ō | Maryland | Baltimore | | • | | Ba | ltimore | | | | | 1 Yes |
| 7.28a | Director | 10e. Street and Number | | | | 10f. Zij | p Code | | | | 10a. Citize | on of What C | Country? |
| 33 o | O E | 4708 Grand Bend [| Orive | | | | | 2122 | 28 | | • | | S.A. |
| nd other than "neturel", or itams 23s or 28s-f show event, the Medical Evar, it at must be notified at | Funeral | 11. Marital Status | 12. Wa | is Decedent Eve | r in U.S. | 13. Was Dece | edent of Hi | spanic Ori | gin? (Spe | ecify Yes or No- Rican, etc.) | 14 | | nerican Indian, |
| or It | y Fu | 1 Never Married 2 Ma | arried 1 [| Yes 2 No es, Give | | 1 ☐ Yes | | Specify: | 1, 7 46110 | riicari, etc.) | | Black, Wh | |
| urel. | d by | 3 Widowed 4 Divorce | ed Yea | ar or Dates: | | | | 135 | | | 3 | респу. | Black |
| "net | Completed | (Specify only high | | eleted) | 1 (| Decedent's Usu (Give kind of wo life. DO NOT u | ork done d | during mos | t of worki | ing | 16b. Kind | of Busines | s/Industry |
| than the My | mc | Elementary/Secondary (0-12) | Col | llege (1-4or 5+) | | | | , emakei | r | | | Own | Home |
| other I Vent, | Be C | 12 17. Father's Name (First, Middle | e, Last) | | | | | 18. Mothe | er's Name | (First, Middle, | Maiden Sı | итате) | |
| marked o | ToB | Cha | arles Johns | son | | | | | | Minn | ie Joh | nson | |
| Importent: If item 27 is marked eny injury or other treumatic e once. | | 19a. Informant's Name/Relation | nship <i>(Type, Prir</i> | nt) | 19b. | Mailing Address | s (Street a | and Numbe | er or Rura | al Route Numbe | r, City or T | own, State, | Zip Code) |
| n 27 ier tr | | Gail Thornton Siste | er | | | | | nd Drive | e Baltii | more, Mary | land 21 | 228 | |
| ant: If iter ary or oth | | 20a. Method of Disposition 1 Burial 2 □ Cremation | 3 DRemoval | I | 20b. Place of I cemetery | Disposition (Na. r, crematory or c | me of other place | e) ! | | Date | 20c. Loca | tion - City o | r Town, State |
| ury o | | '4 □Donation 5 □ Other (| | _ | Elkridge (| Community | / Christ | ian Chu | urch ' | 11/13/06 | E | Elkridge, | Maryland |
| Import eny inj ence. | | 21. Signature of Funeral Service | e Licentre / | 110 | VACC | 22. Name ar | nd Addres | | • | | | | |
| | | | | | Lakele | 1 / - | | | | 10 1 | | | |
| sician edical miner | 36 | 23a. Part1. Enter the disease, shock, or heart failure. Lis immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, | a | Oue to (or as a co | onsequence of | ot enter the moderative Can | de of dying diovas | g, such as cular | Funera ice Bal cardiac o Disea | | P. A 21217 est, | | Approximate Interval Betw Onset and D |
| sician edical miner | ıl Examiner | disease or condition | a b | AC | onsequence of | ot enter the moderate Care (i): | de of dying diovas | g, such as xular | Dise | or respiratory arr | P. A. 21217 est, | | Interval Betw |
| ohysician and the burial-transit the burial-transit | edicai Examin | disease or condition resulting in death) Sequentially list conditions, and a sequentially list conditions, and a sequentially list conditions, and a sequential resulting in death) Last IF FEMALE: 23b. Was decedent pregnant | a | Oue to (or as a co | onsequence of on | ot enter the moonsive Can | de of dying | g, such as xular | Dise | or respiratory arr | est, | d. Date of de | Interval Betwonset and D |
| ohysician and the burial-transit the burial-transit | edicai Examin | disease or condition resulting in death) Sequentially list conditions, as a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: | a | Due to (or as a co | onsequence of onsequence of onsequence of oregnancy | ot enter the moderate Care (i): | de of dying diovas | g, such as xular | Dise | or respiratory arr | est, | | Interval Betwonset and D |
| ohysician and the burial-transit the burial-transit | Physician/Medical Examin | disease or condition resulting in death) Sequentially list conditions, as a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | a | Due to (or as a co | onsequence of onsequence of oregnancy | ot enter the moonsive Carn (i): 3 □ Ectopic pi 5 □ Other (sp. | de of dying dictions of the control | g, such as | cardiac c | or respiratory arr | 230 | d. Date of de Month | Interval Betwonset and D |
| gned by the attending physician and the property of detached for use as the burial-transit to a large transit transit to a large transit transi | by Physician/Medical Examin | disease or con ition resulting in death) Sequentially list conditions, 3 y car y conditions, 3 y car y conditions, 3 y car y conditions, 4 y car y conditions, 5 y car y conditions, 5 y car y conditions, 5 y car y conditions, 5 y car y conditions, 6 y car y conditions, 7 in conditions, 8 y car y conditions, 9 car y car y conditions, 1 | a | Due to (or as a co | onsequence of onsequence of onsequence of oregnancy Fetal death of resulting in the original of the original | ot enter the moonsive Carn (i): 3 □ Ectopic pi 5 □ Other (sp. | de of dying dicvas | g, such as | cardiac c | 23e. Did toi | 230 | d. Date of de Month contribute t | Interval Betw Onset and D |
| rate has been signed by the attending physician and beginning by the attending physician and beginning by the burial-transit beginning by the burial-transit by the burial-trans | Physician/Medical Examin | disease or condition resulting in death) Sequentially list conditions, and all cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | a | Due to (or as a control of the to (or as a contr | onsequence of onsequence of onsequence of oregnancy Fetal death of resulting in the original of the original | ot enter the moonstive Care (i): 3 □ Ectopic pi 5 □ Other (sp. | de of dying dicvas | g, such as | cardiac c | 23e. Did toi 1 \(\triangle Y\) 24a. Was a autops perform | 23c bacco use as 2 \(\text{N} \) | d. Date of de Month contribute to the second of the secon | Interval Betwonset and D Selivery Day Ye To the cause of de Probably 4 (2007) |
| rate has been signed by the attending physician and beginning by the attending physician and beginning by the burial-transit beginning by the burial-transit by the burial-trans | Be Completed by Physician/Medical Examin | disease or con ition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | a | oue to (or as a control of the to (or as a contr | onsequence of onsequence of onsequence of oregnancy Fetal death of resulting in the original of the original | ot enter the moonstive Care (i): 3 □ Ectopic pi 5 □ Other (sp. | regnancy pecify) | n in Part I. | of Death | 23e. Did toi 1 | 23co bacco use es 2 \(\text{N} \) | d. Date of de Month contribute to the state of the state | Interval Betwonset and D polivery Day Yes probably 4 (Decreption of care accompletion of care |
| this certificate has been signed by the attending physician and the print of page 2 should be detached for use as the burial-transit to be printed by the burial-transit to be printed by the page 2 should be detached for use as the burial-transit to be printed by the printed b | To Be Completed by Physician/Medical Examin | Sequentially list conditions, and a season conditions are sulting in death) Sequentially list conditions, and a season cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are summer? 25b. Was case referred to medical examiner? 1 Yes 2 No | a | Due to (or as a control of policy of the control of policy of poli | onsequence of consequence tained the moderation of the underlying of the | regnancy pecify | n in Part I. | of Death | 23e. Did toi 1 | 23c bacco use es 2 N n 2 med? general | d. Date of de Month contribute to the second of the secon | Interval Betwonset and D polivery Day Yes probably 4 (Decreption of care accompletion of care |
| After this certificate has been signed by the attending physician and Solo of the signed by the attending physician and Solo of the Solo o | To Be Completed by Physician/Medical Examin | issass or con ition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | a | Due to (or as a control of policy of the control of policy of poli | onsequence of consequence tent 3 Do | regnancy pecify) cause give A Othe Othe Work Work | n in Part I. 26. Place 4 P. Nui | of Death | 23e. Did toi 1 | 23c bacco use es 2 N n 2 med? general | d. Date of de Month contribute to the second of the secon | Interval Betwonset and D polivery Day Yes probably 4 (Decreption of care accompletion of care |
| tion: After this certificate has been signed by the attending physician and in policy. If the funeral director, page 2 should be detached for use as the burial-transit in policy. | To Be Completed by Physician/Medical Examin | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Phatural 5 Pendiquents in the past 12 months? 27. Manner of Death 1 Phatural 5 Pendiquents investigation in the past 3 No 27. Manner of Death 1 Natural 5 Pendiquents 3 Suicide 6 Coulded | a | Due to (or as a control of the to (or as a contr | onsequence of consequence enter the moon sive Can 3 Ectopic pi 5 Other (sp the underlying c category attent 3 December of aury M | regnancy pecify) cause give A Othe 28c. Injury Work 1 Y | n in Part I. 26. Place | of Death | 23e. Did toi 1 | 23c bacco use es 2 N n 22 No ned? es 6 Sent and N | d. Date of de Month contribute t No 3 P 24b. Were a prior to death? 1 Yes | Interval Betwonset and D polivery Day Yes probably 4 (Decreption of care accompletion of care |
| tion: After this certificate has been signed by the attending physician and in policy. If the funeral director, page 2 should be detached for use as the burial-transit in policy. | Certification; To Be Completed by Physician/Medical Examin | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Patural 2 Accident 3 Suicide 6 Coulded 4 Homicide Continued a condition of the past 12 Certifying | a | Due to (or as a control of policy of the control of policy of the control of policy of policy of policy of the control of policy of the control of policy of the control of | onsequence of consequence tent the moonstive Can 3 Ectopicpi 5 Other (sp the underlying c attent 3 Do me of ury M m, street, factory death occurred | regnancy pecify) cause give A Othe 28c. Injury Work 1 Y | n in Part I. 26. Place 26. Place 4 1 Nu | of Death | 23e. Did toi 1 | 23c bacco use es 2 \(\backsquare \) n nd? 2 \(\backsquare \) e) ence 6 \(\backsquare \) ence 6 \(\backsquare \) ence 7 reet and N n, State) | d. Date of de Month contribute t No 3 P 24b. Were a prior to death? 1 Yes Other (Speccurred | Interval Betwonset and D Day Yes To the cause of de Probably 4 (D) Interval Brown of cause of cause of de Probably 4 (D) Interval Brown of cause of caus |
| tion: After this certificate has been signed by the attending physician and in policy. If the funeral director, page 2 should be detached for use as the burial-transit in policy. | To Be Completed by Physician/Medical Examin | disease or con inton resulting in death) Sequentially list conditions, 3 y cast standard cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | a | Due to (or as a control of or as | onsequence of consequence tent 3 DC attent 3 DC attent 3 DC attent 3 DC attent 3 DC attent 4 actory M n, street, factory death occurred or investigation | regnancy pecify) cause give A Othe 28c. Injury Work 1 Y | n in Part I. 26. Place 26. Place 4 P Nul at e, date and inion, deat | of Death | 23e. Did toi 1 | 23c bacco use es 2 \(\text{N} \) n mad? 2 \(\text{DNo} \) sence 6 \(\text{Downinjury o} \) reet and N, State) ause(s) anate and pla | d. Date of de Month contribute t No 3 P 24b. Were a prior to death? 1 Yes Other (Specurred | Interval Betwonset and D Day Yes To the cause of de Probably 4 (D) Interval Brown of cause of cause of de Probably 4 (D) Interval Brown of cause of caus |
| After this certificate has been signed by the attending physician and Solo of the signed by the attending physician and Solo of the signer of | edical Certification; To Be Completed by Physician/Medical Examin | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit | a | Due to (or as a control of or as | onsequence of consequence tent 3 DC attent 3 DC attent 3 DC attent 3 DC attent 3 DC attent 4 actory M n, street, factory death occurred or investigation | regnancy pacify) DA Othe 28c. Injury Work 1 Y y, office at the time, in my op c. License | n in Part I. 26. Place 26. Place 4 P Nul at e, date and inion, deat | of Death sing Hon 2 No 2 d place, a | 23e. Did toi 1 | bacco use es 2 \(\backsquare \) n 23c n 23c n 2 \(\backsquare \) n 2 \(\backsquare \) n 2 \(\backsquare \) e) ence 6 \(\backsquare \) e | d. Date of de Month contribute t No 3 P 24b. Were a prior to death? 1 Yes Other (Speccurred | Interval Betwonset and D polivery Day Ye to the cause of de probably 4 (Defrication of causes) autopsy findings and completion of causes s 2 No polify) Bural Route Number s stated. e to the cause(s) |
| tion: After this certificate has been signed by the attending physician and in policy. If the funeral director, page 2 should be detached for use as the burial-transit in policy. | edical Certification; To Be Completed by Physician/Medical Examin | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit | a. D b. D c. D d. 23c. If ye solutions contribution al Hospital: Hospital: 28a. ing tigation of not be mined and possible the solution of the mined solution of the mined solution of the solution of the mined solution of the mined solution of the mined solution of the | Due to (or as a control of the form of the | onsequence of pregnancy of death of dea | adient 3 Dome of 2 aury Mn, street, factory investigation | regnancy pacify) DA Othe 28c. Injury Work 1 Y y, office at the time, in my op c. License | n in Part I. 26. Place 26. Place 4 Nu 4 Nu e, date and inion, deat | of Death sing Hon 2 No 2 d place, a | 23e. Did toi 1 | bacco use es 2 \(\backsquare \) n 23c n 23c n 2 \(\backsquare \) n 2 \(\backsquare \) n 2 \(\backsquare \) e) ence 6 \(\backsquare \) e | d. Date of de Month contribute t No 3 P 24b. Were a prior to death? 1 Yes Other (Specurred | Interval Betwonset and D polivery Day Ye to the cause of de probably 4 (Defrication of causes) autopsy findings and completion of causes s 2 No polify) Bural Route Number s stated. e to the cause(s) |

| | | | State of Maryland 1- State Registrar | / Depa | | t of H | ealth and M | lental Hyg | _ | 06 | 37764 |
|--------------------------|---|----------------------------|---|----------------------------|------------------------------|-------------------------------|--|----------------------------------|--|---|---|
| į. | Physici /Medic Examir | al | Decedent's Name (First, Middle, Last) Kenneth T. E 4a. Facility Name (If not institution, give street and number) | Boone | T | Town, or | Location of Death | 2. Date of Dea Month NCV | 24 | Year 2006 by of Death | 3. Time of Death |
| | - Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. las 220-64-7816 48 | st birthday) Yrs. | If Under Months | ALT 1 Year Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day | | 9. Birth | /A place (State or Foreign ntry) Maryland |
| | Maryland a-f ehow | ctor | Usual Residence of Decedent 10a. State 10b. County 10c. City, Maryland N/A | Town or Lo | ocation | Ва | altimore | | | | 10d. Inside City Limits 1 XYes 2 □ No |
| | ath with the 23a or 28 | ral Dire | 10e. Street and Number 408 Westshire Road | | 10f. Zip | | 21229 | | 0g. Citizen of | U.S. | Α. |
| 9003 | within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-f ehow he Madical Examinar must be notified at | d by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 1 ☐ Yes 2 | 2 □X No | spanic Origin? (Sp n, Mexican, Puerto Specify: | ecity Yes of No- Rican, etc.) | Spec | | etc. Black |
| 21215-0036 | filed within 72 I Hygiene. other than "nat | Completed | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 | (Give | DO NOT us | k done d e retired | furing most of work Service Dept. | | 16b. Kind of I | Airp | |
| Maryland 21 | should be filed and Mental Hygi is marked other aumatic event, I | To Be | 17. Father's Name (First, Middle, Last) John Boone Jr 19a. Informant's Name/Relationship (Type, Print) | 10b Maili | ng Addroso | (Street s | 18. Mother's Name | Val | eria Boor | ne | a Codel |
| Baltimore, Ma | es 1 and 3 of Health if Item 27 or other tr | | Bridget R. Boone Wife | de of Disponetery, crei | - | tshire ne of ther place | Road Baltimo | | d 21229 20c. Location | | own, State |
| Balti | permit. Pag Department Important: I any injury o | | 21. Signature of Funeral Service Licensee | 2 | 2. Name and Es | d Addres | s of Facility rothers Fune rtaw Place Ba | altimore, Mo | 21217 | | |
| - | Physician /Medical Examiner | | 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseque | AL | TAM | PONI | ADE | or respiratory arr | est, | | Approximate Interval Between Onset and Death 2 HOURS |
| 68760, | sician and | dicai Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a conseque of the consequence | | • | | FUSION S CELL OF TO | CARCI NSIL | voma | | 2 DAYS 7 MONTH |
| P.O. Box 6 | res that the death certificate igned by the attending phy be detached for use as the | Completed by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea | ieath 3[| ⊒Ectopic pro ⊒ Other (spo | | | | | ate of deliver | ery Day Year |
| Ś | w requires that been signed b should be deta | ed by PI | Part II. Other significant conditions contributing to death but not result NEUTROPENIA SECONDA | - | | _ | on in Part I. | | bacco use cor es 2 \(\subseteq \text{No} | ntribute to t | he cause of death? |
| al Recc | r: The law re cate hes be r, page 2 sho | | | | | | | 24a. Was a autop: perform | med?_ | Were auto prior to co death? 1 Yes | ppsy findings available impletion of cause of 22 No |
| Division of Vital Record | To the Hospitel or Attending Physician: The lawithin 24 hours effer death. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2 | Certification: To Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatient 2 Eff 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At hom building, etc. (Specify) | 28b. Time o Injury | M 2 | 8c. Injury Work | at ? /es 2 \(\subseteq No | me 5 ☐ Residi 28d. Describe h | ence 6 Ot | irred | y) al Route Number, |
| ō | Hospitel or 24 hours eft Funerel Di tely filled in | edicai Cer | 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination | ledga daat on and/or in | h cocurred to | at the tivi | e, data and place, inion, death occurr | and dua to the n | auso(s) and u | Take of as a | teled the cause(s) |
|) | To the within 2 To the comple | Med | 29b. Signature and title of certifier Mau Mau Mau Mau Mau Mau Mau Ma | | | _ | 9908 | 2 | 9d. Date sign | | Day, Year) |
| | | ate | 30. Name and address of person who completed cause of death (Item 2 MANISM SINGM, ST AGN) 31. Date filed (Alonth, Day, Year) 32. Registrar's Signatu | VES | NOS | PIT | AL, B | PALTIMO | ORE - | 212 | 29 |
| DI | Regist | | NOV 2 9 2006 Seem | No 1 | | | | | C | | |

| | | 1- For State Registrar | State of Maryla | | artment of H <i>rtificate of L</i> | | - 1 | giene Reg. No. 🔿 ∩ | 00 | 07765 |
|---|----------------|---|---|--|--|---|------------------------------------|-----------------------------------|--------------------------|---------------------------------|
| | | Decedent's Name (First, Middle, La | ast) | | | | 2. Date of Dea | ath — U | U D | 3. Time of Death |
| Physic | | | Helen | Barth | olomey | | Month Novemb | er 24, | Year 2006 | 4:29 A M |
| /Med Exami | | 4a. Facility Name (If not institution, gir | ve street and number) | | | Location of Death | | 4c. County | | |
| LAGIII | | Gilchrist Center | c | | Towson | | | Bal | timor | e Co. |
| Funera | | Social Security Number 6. | Sex 7. Age (In yr | s. last birthday) | If Under 1 Year_ | If Under 24 Hrs. | 8. Date of Birt | h . | 9. Birthp | lace (State or Foreign try) |
| Director | | 218-05-9160 | 1□M 3√3F 92 | Yrs. | Months Days | Hours Min. | (Month, Day May 3, | | Mich | <i>try)</i> .igan |
| | | Usual Residence of Decedent | | | | | 7 - 7 | | | |
| /lanc | | 10a. State 10b. County | 10c. C | City, Town or Lo | cation | | | | 1 | 0d. Inside City Limits |
| Man, f sh | 호 | Maryland Ba | ltimore | | | | Towso | n | | 1 ☐ Yes 🏋 No |
| the 28a notif | Director | 10e. Street and Number | ICIMOIC | | 10f. Zip Code | | | 10g. Citizen of | What Coun | try? |
| d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or items 23a or 28a-f show ent, the Medical Examiner must be notified at | | 4607 Kenwood A | vanua | | | 21206 | | United | Stat | es |
| eath ns 23 mus | Funeral | 11. Marital Status | 12. Was Decedent Ever in | U.S. 13. V | Nas Decedent of Hi Yes, specify Cuba | | ecify Yes or No- | | e - Americ | |
| ter d item | <u>ا</u> يا | 1 □ Never Married 2 □ Married | Armed Forces? | | f Yes, specify Cuba | n, Mexican, Puèrto | Rican, etc.) | Blac | ck, White, | etc. |
| I, or xami | by | 3 ₩idowed 4 Divorced | 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | | 1 ☐ Yes 2 🙀 No | Specify: | | Specif | y: Wh | ite |
| hou trura | be | 15. Decedent's E | ducation | 16a. Deced | dent's Usual Occupa | ation | | 16b. Kind of B | | |
| T 72 in 72 in edice | Completed | (Specify only highest gi | rade completed) | (Give | kind of work done of DO NOT use retired | luring most of work.) | ing | | | · |
| with with than | Ę | Elementary/Secondary (0-12) 8 Years | College (1-4or 5+) | Hom | nemaker | | | Own | Home | |
| d 21 filed wi Hygien other th | | 17. Father's Name (First, Middle, Las | t) | 1101 | | 18. Mother's Name | (First, Middle, | Maiden Surnar | ne) | |
| and the label the label ed o | Be | John Romecki | * | | | Maqdal | ine Zac | kewski | | |
| Maryland 2 12 should be filed h and Mental Hygi is marked other traumatic event, ti | မ | 19a. Informant's Name/Relationship | (Time Brint) | 10h Mailir | ng Address (Street a | | | | Stata Zin | Cada) |
| Maryland 21213-UU36 td 2 should be filed within 72 hours af tth and Mental Hygiene. 77 is marked other than "natural" or traumatic event, the Medical Exami | - | Johnette Olsson | | | amellia Co | | | , Maryl | | 21234 |
| IOTE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If item 27 is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | | 20a. Method of Disposition | | | | | Date | 20c. Location | | |
| Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other | | 1 ■ Burial 2 □ Cremation 3 | | | sition (Name of matory or other plac | . I | | | • | |
| LIM Fried France | | Donation 5 ☐ Other (Spec | | Contract of the last of the la | Cemetery | | 006 | Baltim | ore, | Maryland |
| Kall permit Depart Import any In | | 21. Sig Nure of Funeral Service Lige | ensee | D1 22 | 2. Name and Addres ida—Ruck I | ss of Facility Funeral H | ome of | Dundalk | . Inc | |
| n goe g | | 1)4 | . Carl | 17 | 922 Wise | Ave. Du | ndalk. | Marylan | | |
| | 1 | 22a. Part1. Enter the disease, or con shock, or heart failure. List only | nplications that caused the de y one cause on each line. | ath. Do not ent | er the mode of dyin | g, such as cardiac | or respiratory ar | rest, | [1] | Approximate Interval Between |
| Physician | | Immediate Cause (Final disease or condition | SUBDUR | | Hena | toma | | | - 1 | Onset and Death |
| /Medica | | resulting in death) | Due to (or as a cons | equence of): | | _ | | 0 | | |
| Examine | | | h | | | | ~11 | 4 | | |
| Marine Marine | बुं | Sequentially list conditions, if any, leading to immediate | Class to for as a cons | equence of): | | _9 | 75 | - | - | |
| d ansit | Examiner | Sequentially list conditions, it dry, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | C | | | 40 | The state of | 10, | | |
| O, exec un an rial-tr | Ä | resulting in death) Last | Due to (or as a cons | equence of): | | 100 | N/X | X-/ | | |
| 68760, filicate be executed g physician and as the burial-transit | edical | | d | | | MA. | De Si | ~~ | | |
| 68 iffical g ph) as th | | | | | | 11 - | to L | 0/1 | | |
| Box eath cert attending for use a | 1 | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome pf preg | | 7 | | 3 | 23d. Da | ate of delive | ery |
| atte for | Physician/M | in the past 12 months? 1 ☐ Yes 2 No | 1□Live birth 2□Fe 4□Pregnant at time o | | ⊒Ectopic pregnancy ⊒ Other <i>(specify)</i> | . 55/ | · · / | Me | onth | Day Year |
| P.O. that the de | ıysi | 9 Unknown | 9□Unknown | | | 1/2 | ۲ | | | |
| that ed b | | Part II. Other significant conditions | contributing to death but not r | esulting in the u | nderlying cause give | en i /Pa/I. | 23e. Did to | obacco use con | tribute to th | ne cause of death? |
| ds uires sign d be | g p | 'telvic Frad | ture Ham | -tall | 2 | 1 | 1 🗆 ' | res 200 No | 3 ☐ Prob | ably 4 Unknown |
| Records, P.O. Box (The law requires that the death certif the has been signed by the attending age 2 should be detached for use a | Completed by | | | | | | 24a. Was | an 24h | More auto | psy findings available |
| Division or Vital Records, I or Attending Physician: The law requires t after cleath. I Director: After this certificate has been signe d in by the funeral director, page 2 should be | 臣 | | <u></u> | | | | autor | | | mpletion of cause of |
| Th: Th | S | | | | | | 1□ Yes | 25No | 1 🗆 Yes | 2 □ No |
| Vision or Vita Attending Physician: r death. ector: After this certifica by the funeral director, I | Be | 25. Was case referred to medical examiner? | Hospital: | | Oth | 26. Place of Deat | | | | Hac O. a.s. |
| hysi hysi this c | ြို | 1 Yes 2 No | 1 Inpatient 2 | ☐ ER/Outpatier | | 4 LI Nursing Ho | | | | HOSPICE |
| ng P | Ë | 27. Manner of Death 1 ☐ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time o Injury | _ Worl | | - | now injury occur | | |
| endi eath. or: A | ä | 2 Accident investigation | 7,0.,000 | | | | reel | 12/00 | m | |
| r Att | Certification: | 3 Suicide 6 Could not 4 Homicide determine | building, etc. (Spe | CIIY) | | GOWEN | 28f. Location (3 City or To | Street and Numi vn, State) | ber or Run | BROUTE Number |
| ital c | S | | Assisted 1 | | | DASI | | CONCIO | | WD SISS |
| losp hou unel | ca | 29a. Certifier 1 ertifying F (Check only 2 Medical Ex | Physician: To the best of my kaminer: On the basis of exam | nowledg , at ination and/or in | h occurred at the tile execution, in my o | e, date and place, pinion, death occur | and due to the red at the time, | cause(s) and m date and place, | anner as s and due to | tated. the cause(s) |
| Division or Vital Red To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Medical | one) | and manner stated. | | | | | | | |
| Vith To 1 | Σ | 29b. Signature and title of certifier | 0 0 | | 29c. License | e number | | 29d. Date signe | ed (Month, | Day, Year) |
| | | EXPENDED O | (It oulll | 4 | 10.9 | -0045 | | 11/20 | +/0 | eo 6 |
| | 11 | 4 101400 | | | | | | | | |
| 1 | | 30. Name and address of person wh | o completed cause of death (II | tem 23a) (Type, | Print) | - / [|) | 0. 2 | / | - 41 |
| 5 | | 30. Name and address of person where dell Pov | | tem 23a) (Type, | Print) Charles | st/ [| Balto | WD | 9190 | 04 |
| 5 | tate | 30. Name and address of person where Accel 12000 | | em 23a) (Type, | Print) Charles | st/ (| Balto | WD | 9190 | 04 |

| | | | For Amerid #5 Per State Registrar 1. Decedent's Name (First, Middle, Last) | State of Mary and | 967 Pepart Certii | ment of H | ealth and I Death | 2. Date of Dea | Reg. No. ath | 37766 |
|-------------|---|----------------|---|--|--|--|--------------------------------|--|--|--|
| | Physicia /Medic Examin | al | 4a. Facility Name (If not institution, give si | | _Se_ | b. City, Town, or | Location of Deatl | Noven | Day Year 100 A 20 4c. County of Dea | N3: Wp M |
| | Funeral Director | | JOHNS HOP 5. Social Security Number 6. Sex 28 218–24–6449 | KINS BA 7. Age (In yrs. 75 | | BAL f Under 1 Year lonths Days | If Under 24 Hrs. Hours Min. | 8. Date of Birt (Month, Da March 1 | y, Year) C | thplace (State or Foreign ountry) aryland |
| | Maryland a-f chow | tor | Usual Residence of Decedent | 10c. Cit | y, Town or Locat | | imore Ci | ty | | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No |
| | with the | Dire | 10e. Street and Number 619 South Linwoo | d Avenue | | 10f. Zip Code | 21224 | | 10g. Citizen of What C United St | |
| 336 | 72 hours after death with the Maryland naturel; or items 23a or 28a-f ehow lical Examiner must be notified at | by Funeral | | 2. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Kore | 1. | s Decedent of Hi es, specify Cuba Yes 2 2 No | | Specify Yes or No to Rican, etc.) | 14. Race - Am Black, Whi Specify: | |
| 1215- | within 72 ane. than "nai | Completed | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) | ation | 16a. Deceden (Give kin life. DO | NOT use retired | furing most of wo | - | 16b. Kind of Business | /Industry |
| pu | id be filed ental Hygi ked other c event, | To Be Co | 12 Years 17. Father's Name (First, Middle, Last) Joseph W. Base | | Regiona | T Brane | 18. Mother's Nar | | Maiden Sumame) | |
| | d 2 shoth and the and traum | | 19a Informant's Name/Relationship (Type Mrs. Ruth Base | (Wife) | 1 | | and Number or Ri nwood Av | | er, City or Town, State, cimore, Mar | Zip Code) yland 21224 |
| Baltimore, | permit. Pages 1 an Department of Heal Important: If Item 2 eny Injury or other once. | | 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) | emoval from State | Place of Dispositi Temetery, cremat Ly Rosar | ory or other plac y Cemet | ery 11/ | Date 27/2006 | | e, Maryland |
| Balt | Departi Departi Import eny Inj | | 21. Signature of Funeral Service License | Jaston 2 1 | 792 | 2 Wise_ | Ave. Du | ndalk, M | Dundalk, I Maryland 2 | nc. 1222 Approximate |
| | Physician /Medical | | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) | STRO | KE | ne mode or dyin | g, such as cardia | c or respiratory at | rrest, | Interval Between Onset and Death |
| 8760, | Examiner | icai Examiner | Sequentially list conditions, Il any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conseq | uence of): | | | | | 2 DAYS |
| P.O. Box 68 | ne death certific the attending p thed for use as | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown | Ideath 3 ⊟Ed | ctopic pregnancy ther (specify) | | | 23d. Date of de Month | olivery Day Year |
| rds, P. | w requires that the bean signed by should be detact | ρ | Part II. Other significant conditions con | tributing to death but not res | ulting in the unde | erlying cause give | en in Part I. | | obacco use contribute t Yes 2 ☐ No 3 ☐ P | o the cause of death? robably 4 @Unknown |
| Il Records, | The law resate hes being page 2 sho | Completed | | | | | | 24a. Was autor perfo 1 Yes | an 24b. Were a prior to death? 2 No 1 \(\text{ Ye} \) | utopsy findings available completion of cause of s |
| Vital | Physicien: Th this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | lospital: | | all Doa Oth | 00 | ath (Check only o | | |
| of | Jing After fune | ation: To | 1 Yes 2 2 No 27. Manna of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injun | 4 Nursing r | T | dence 6 Other (Sp. | эспу) |
| Division | | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At h building, etc. (Speci | | t, factory, office | | 28f. Location (City or To | Street and Number or F wn, State) | tural Route Number, |
| | To the Hospital or within 24 hours after To the Funeral Dir completely filled in | edical | | sician: To the best of my kno ner: On the basis of examina and manner stated. | | | | | | |
| | To the comp | Σ | 29b. Signature and title of certifier | D W | | 29c. Licens | | | 29d. Date signed (Mon | 1 |
| | | | Manjala | 4 Jyour | 7 | RE | 5-000 | / | Vovember | ,2006 |
| | 5+1 | | 30. Name and address differson who co | T. Gipson | | Eas | tern A | renue | Baltimo | , 22, 2006 re, ND21224 |
| * | Sta Regista | | 31. Date filed (Month, Day, Year) NOV 2 9 200 | 32 Registrar's Sign | | Les . | | | | |

| | | | 1 - For State Registrar | State of Marylar | | rtment of F | | | giene (| 006 | 37767 |
|---------------------|--|---------------------|--|---|-----------------------------------|--|-------------------------------------|--|----------------------------|--|--|
| | Physici | | 1. Decedent's Name (First, Middle, Last | | -ke | | | 2. Date of Dea Month | Day | Year , | 3. Time of Death 2.3.2.3 M |
| | /Medio Examin | | 1000 00. | Hospital (. | enter | 4b. City, Town, o | r Location of De | town | 4c. Cou | nty of Death | ore |
| | Funeral Director | | 220 20 0427 | 7. Age (In yrs. 82 | Yrs. | Months Days | Hours M | | y, Year) | Virgi | |
| | Maryland B-f show | tor | Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor | | ity, Town or Lo | | | | | 10d. | . Inside City Limits 1 ☐ Yes 2 ☒ No |
| | with the | i Direc | 10e. Street and Number 126 Smithwood Ave | niie | | 10f. Zip Code 21228 | 3 | | 10g. Citizen USA | of What Country | ? |
| 920 | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinat must be notified at | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 \(\) Widowed 4 Divorced | 12. Was Decedent Ever in U Armed Forces? 1 Mayes 2 Mo If Yes, Give Year or Dates: | | Vas Decedent of H i Yes, specify Cuba | lispanic Origin? an, Mexican, Pu | (Specify Yes or No- erto Rican, etc.) | 14. F | Race - American Black, While, elc city: Whit | · |
| Maryland 21215-0036 | e filed within 72 ho al Hygiene. other than "naturi vent, the Madical | Completed | 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) | | (Give life. L | lent's Usual Occup kind of work done OO NOT use retired ICK Drive | during most of v d) | working | | f Business/Indus | • |
| land ; | should be filed and Mental Hyg marked othe umatic event, | To Be C | 17. Father's Name (First, Middle, Last) William W. Burke | | | | | Name (First, Middle, C. Nichol | | name) | |
| | and 2 shout salth and Me n 27 is mari | / 7/4 | 19a. Informant's Name/Relationship (T) Janet L. Onion S | | | | | Rural Route Numbe Catonsvil | | | |
| Baltimore, | | | 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, | Tellioval Holli State | | sition (Name of natory or other place | 1 | Date | | on - City or Town | |
| Baltir | permit. Page Department of Important: If any Injury or once. | | 21. Sign ure Funeral Service Licens | | 22 F1 | . Name and Addre ineral Ho | ome of | 2/1/2006 Lelring As atonsvill | hton S | Schwab W | Vitzke |
| | Physician | 4 15 | 23a. Part1. Ehter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition | ications that caused the deane cause on each line. | th. Do not ente | er the mode of dyir | ng, such as card | renue; Cat liac or respiratory ar | rest, | Ar | pproximate iterval Between |
| 8760, | Medical Examiner be executed by sicial and burial-transit | icai Examiner | cause. Enter Underlying Cause (Disease or injury | b. Die to (or as a consect. Due to (or as a consect. Due to (or as a consect. | quanna of): | | | | | | |
| P.O. Box 68 | The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet: 4 □ Pregnant at time of one of the companion of the c | aldeath 3□ | Ectopic pregnancy Other (specify) | , | | 1 | Date of delivery Month Da | ay Year |
| | quires that n signed b uld be deta | ρ | Part II. Other significant conditions co | | | oderlying cause giv | ren in Part I. | | obacco use c ∕es 2 □ No | onIribule to the o | / |
| Vital Records, | | Completed | | | | | Ű | 24a. Was autop perfo 1 ☐ Yes | rmed? | prior to compl death? | y findings available letion of cause of |
| f Vita | Physiclan: this certificanal director, | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: 1 ☐ Inpatient 2 🕽 | ER/Outpatien | t 3 DOA Oth | 105 | Death <i>Check only o</i> | | Other (Specify) | |
| Division of | ath. oath. or: After | | 27. Manner of Death 1° ☐ Autural 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be | 28a. Dale of Injury (Month, Day Year) | 28b. Time of Injury | | yat rk? Yes 2 □ No | 28d. Describe h | | | |
| DİXİ | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | Certification | 4 Homicide determined | 28e. Place of Injury - At the building, etc. (Special Control of the building) and the building in the buildin | ify) | | | City or Tox | vn, State) | Imber or Rural R | |
| | To the Hosp within 24 hou To the Fune completely fil | Medical | (Check only 2 Medical Exam | sician: To the best of my kn iner: On the basis of examin and manner stated. | owledge, death ation and/or in | estigation, in my o | opinion, death o | ccurred at the time, | date and plac | ce, and due to the | e cause(s) |
| | or with | 2 | 29b. Signature and title of certifier | two | | D D | ose number | 319 / | 29d. Date sig | med (Month, Day | y, Year) 26204 |
| - | 5 X1 | | and address of person who co | ompleted cause of death (Ite | m 23a) (Type, | 401 F | ord C | 975 70 | ed | Mar | 262006 yland |
| | Sta Regist | | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | k 6 | we | | | | | V |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 17 per inf 9862 12-4-06 vt
State of Maryland / Department of Health and Mental Hygiene 2 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician MARTIN **BERGER** 9:56 AM November 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore oitalof N/A Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) cial Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 03/06/1932 1 M 2 □ F 212-44-8460 CANADA Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 1 ☐ Yes 2 ☑ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with USA 3801 LOCHEARN DRIVE 21207 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 72 hours after 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) be filed within 7 ial Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) PHYSICIAN MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **JOSEPH** JOSPHEN BERGER REBECCA **MEYERS** ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3801 LOCHEARN DRIVE - BALTIMORE, MD 21207 JUDITH BERGER / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 □Removal from State 1 X Burial 2 ☐ Cremation CHOFETZ CHAIM CEM. 11/27/2006 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Videns 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arrest, Interval Between conset and Death Immediate Cause (Final Bowe pertoration **Physician** disease or condition resulting in death) /Medical Due to (or as a conse uence of) Examiner 21 days multi-organ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence) Examine attending physician and for use as the hirrial. to asset the hirrial. that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 4□Pregnant at time of death 9□Unknown in the past 12 months? Month Year 5 ☐ Other (specify) ned by the al 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use gontribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy performed 2 No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred il or Attending Fafter death. After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOVEMBER 25 2006 MO PhD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAL HOSPITAL OF BALTIMORE CHRISTIAN 31. Date filed (Month, Day, Year) State Registrar

| | | | for State Registrar | State of M | aryland | | artment <i>tificate</i> | | | ind Me | | jiene | 006 | 37769 |
|---------------------|--|------------------|---|--|---------------------|-----------------------------|--|---------------------|----------------------------|-------------|---------------------------------|---------------|-------------------------|--|
| | T | | Decedent's Name (First, Middle, Las | t) | | | | | | - (| 2. Date of Dea | th | | 3. Time of Death |
| 1 | Physici /Medic | | MARY CHARLO | OTTE BE | EIERLI | | | | | I | Month Novembe | r 23. | 2006 | 9:55 A.M |
| | Examin | | 4a. Facility Name (If not institution, give | street and number) | | | 4b. City, To | own, or 1 | ocation o | | | | inty of Death | |
| | | . 3 | Maria Health Car | | | | | Ltim | | | | Bal | timore | 9 |
| | Funeral | | 5. Social Security Number 6. Se | 9x 7. Ag □M 2t∇F | je (In yrs. la: | st birthday) Yrs. | If Under 1 Months | Year Days | If Under 2 Hours | Min. | B. Date of Birth (Month, Day | (Year) | 9. Birthp | lace (State or Foreign Tand |
| -4 | Director | | 218-64-2171 Usual Residence of Decedent | -X- | 94 | TIS. | | | | A | pr. 7, | 1912 | Mary | rland |
| | land land | | 10a. State 10b. County | | 10c. City, | Town or Lo | cation | | | | | | 1 | 0d. Inside City Limits |
| | Mary -1 sh | ğ | Maryland Baltimo | ro | | Balti | more | | | | | | | 1 ☐ Yes 2 No |
| | 1 the | rec | 10e. Street and Number | LG | | Dares | 10f. Zip C | ode | | | | l0g. Citizen | of Whal Cour | itry? |
| | uter death with the Marylan r Iteme 23a or 28a-f show itrects and be neithing at | Funeral Director | 6401 N. Charles S | Street | | | | 21 | 212 | | | II. | S.A. | |
| | death | ner | 11. Marital Status | 12. Was Decedent Armed Forces? | | . 13. \ | Was Decede | | | gin? (Spec | ify Yes or No- ican, etc.) | | Race - Americ | |
| 9 | after dea or Iteme | F | 1 X Never Married 2 ☐ Marned | 1 ☐ Yes 2 ☑ If Yes, Give | | | 1 ☐ Yes 2) | | Specify: | , i dono ii | iodii, oto., | | Black, White, | |
| 8 | 172 hours after death with the Maryland "natural", or Iteme 23s or 28s-f show with Eath International burneilfied at | d by | 3 ☐ Widowed 4 ☐ Divorced | Year or Dates: | | | | | | | | | ' Whi | |
| 7 | "nat | iete | 15. Decedent's Ed (Specify only highest grad | | | (Give | lent's Usual kind of work DO NOT use | done du | ion i <i>ring m</i> ost | of working | 9 | 16b. Kind a | f Business/Ind | dustry |
| 12 | J within 72 hours a piene. r then "natural", o | Completed | Elementary/Secondary (0-12) | College (1-4or: 5+ | 5+) | | eacher | , | | | 1 | Paroc | hial S | ahoo1 |
| 0 | Hyg Hyg ent, | 0 | 17. Father's Name (First, Middle, Last) | | | | Cacilei | | 18. Mothe | r's Name (| First, Middle, | | | CHOOL |
| Maryland 21215-0036 | 2 to 5 | To B | Frank Be: | ierli | | | | | Mago | lalen | а | Zieh | 1 | |
| ary | should and Men marke umatic | | 19a. Informant's Name/Relationship (7 | ype, Print) | | 19b. Mailir | ng Address (| Street ar | | | Route Numbe | r, City or To | wn, State, Zip | Code) |
| Σ | 5 € Z = Z | | Bernice Feilinger | , S.S.N.D | • | 6401 | N. Cha | ırle | s Str | eet | Baltin | nore, | Maryla | nd 21212 |
| ore | | | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ | Removal from State | 000 | ce of Dispo netery, crem | sition (Name natory or oth | of er place, |) | Da | te | 20c. Location | on - City or To | wn, State |
| Baltimore, | permit. Pages Department of I Important: If It any Injury or o | | 4 □ Donation 5 □ Other (Specify | | Vil | | ria Ce | | | | | Glen A | Arm, Ma | ryland |
| Salt | Depart Depart Import any Inj once. | | 21. Signature of Funeral Service Licen | see | | M 22 | Name and | Address I-Wi | of Facility | eld F | uneral timore | Home | Inc | |
| a line | 00 F 4 0 | | Deorge fort | evane | | (| 5500 Y | ork_ | Road | Bal | timore | , Mary | land 2 | 21212 |
| | | | 23a. Part1. Enter the disease, or composhock, or heart failure. List only | one cause on each li | ine. | | | | | | respiratory arr | est, | | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a | PEB! | 186 | 141 | (cn | Bes | ·/> | | | | |
| 46 35 | Examiner | | 1 | Due to (or as | a conseque | ince of): | | | | | | | | |
| | | er | Sequentially list conditions, if any, leading to immediate | b. Due to (or as | a conseque | nce of): | | | | | | | | |
| V | uted d ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | С. | | | | | | | | | | |
| ó | be executed icien and burial-transit | Exa | resulting in death) Last | Due to (or as | a conseque | nce of): | | | | | | | | |
| 8760 | e s e | lical | (| d | | | | | | | | | | |
| 9 | eath certifica attending ph for use as the | Mec | IF FEMALE: | 22- 4 | | | | | | | | | | |
| Вох | attend for us | ian/ | in the past 12 months? | 23c. If yes, outcome 1☐Live birth | 2 Fetal d | leath 3 | Ectopic preg | | | | | 23d. | Date of delive Month | ry Day Year |
| - | the death certifica y the attending phiched for use as th | Physician/Med | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 4□Pregnant a 9□Unknown | t time of dea | ım ə∟ | Other (spec | :my) | | | | | | |
| P.0 | that the de ned by the a detached f | | Part II. Other significant conditions co | ontributing to death b | out not result | ing in the u | nderlying cau | ise giver | n in Part I. | | 23e. Did to | bacco use c | ontribute to th | e cause of death? |
| Records, | The law requires that ate hes been signed b page 2 should be deta | d by | | | | | | | | | 1 □ Y | es 22N | 3 Prob | ably 4 □Unknown |
| 00 | aw require as been sig 2 should b | Completed | | | | | | | | | 24a. Was a | | b. Were auto | psy findings available |
| Re | The lar | E O | | | | | | | | | autops perfor | med? 2 No | death? | npletion of cause of 2 No |
| of Vital | | BeC | 25. Was case referred to medical examiner? | | | | | | 26. Place | of Death | Check only or | | | 20110 |
| <u>_</u> | Physician: this certific ral director, | 10 | 1 Yes 2 No | | ent 2 E | R/Outpatien | t 3 DOA | Other | 4 Nu | rsing Hom | e 5 🗆 Resid | ence 6 🗆 | Other (Specify | 1) |
| 0 _ | | | 27. Manner of Death 1. ☑ Natural 5 ☐ Pending | 28a. Date of Inju (Month, Da | iry 2 iy Year) 2 | 8b. Time of Injury | | : Injury : Work? | | | 3d. Describe h | ow injury oc | curred | |
| Sio | ten leat tor: the | cati | 2 Accident investigation 3 Suicide 6 Could not be | . | | | М | | es 2 🗆 N | | | | | |
| Division | i di i | Certification: | 4 Homicide determined | 289. Place of in | ic. (Specify) | ie, tarm, str | eet, factory, | office | | 28 | City or Tow | | imber or Hura | l Route Number, |
| | Hospitel | | 29a, Certifier 1 Certifying Ph | ysician: To the best | of my knowl | ledge, death | occurred at | the time | date and | d place, an | nd due to the c | ause(s) and | manner as st | ated |
| | To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by | Medical | (Check only 2 Medical Examone) | iner: On the basis of and manner st | of examination | on and/or inv | estigation, in | n my opi | nion, deat | h occurred | d at the time, d | ate and plac | ce, and due to | the cause(s) |
| | To the within To the Comp | ž | 29b. Signature and title of certifier | , / | | | | License | | | Z | 9d. Date sig | ned (Month, | Day, Year) |
|) | | | Manes. | Xaves (| Sern | 1000 | $-\mid \mathcal{D}$ | CC | 13 | 73 | | NOU | 27: | 2006 |
| | 1 | | 30. Name and address of person who | • | , | | , | | | | | | | <u> </u> |
| | 1 | | Francis Xavier C | | | 7505 C | sler I | riv | e Tov | vson, | Maryla | and 21 | 204 | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 2 9 2006 | 32. Registr | ar s Signatu | Bones | 2 | | | | | | | |
| 10 | (72.9) Julius | | THUV A J LUUU | SPECIFICATION SPECIFICATION | d | - | = '_ ' | | | | | | | |

| | | | State 6 | of Maryland | / Depa | artment of H | lealth an | d Mental Hy | giene | |
|---------------------|---|------------------|---|--|---|--|----------------------------------|---|------------------------------------|--|
| | | | 1 - State Registrar | | Cei | tificate of I | Death | | Reg. No. 2006 | 37770 |
| | Physici | an | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of De. Month | ath Day Yea | |
| | /Medic | al | VIRGINIA | umbor) | C | OOK 4b. City, Town, or | Logation of F | NOVEMBE | R 28, 2006 | |
| 44 | Examin | er | 4a. Fecility Name (If not institution, give street and n FOREST HILL HEALTH & R. | | FR | | FOREST | | | FORD |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. las | | If Under 1 Year | If Under 24 | | | irthplace (State or Foreign Country) |
| \$, | Director | | 216-20-2740 1 M 2 DXF | 86 | Yrs. | Months Days | Hours | | | Virginia |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, 1 | Town or Lo | cation | | | | 10d. Inside City Limits |
| | Maryl -fehc liede | tor | MD Harford Co. | Pol | Air | | | | | 1 ☐ Yes 2 📉 🛇 o |
| | h the | irec | 10e. Street and Number | Der | MII | 10f. Zip Code | | | 10g. Citizen of What | Country? |
| | within 72 hours after death with the Maryland ene. Than "natural", or itema 23a or 28a-f ehow The Medical Examinar must be notified at | Funeral Director | 118 Chatham Road | | | 210 | 014 | | United S | tates |
| | er de stema | nue | Armed F | | 13. | Was Decedent of H f Yes, specify Cuba | ispanic Origin In, Mexican, P | ? (Specify Yes or No Puerto Rican, etc.) | - 14. Race - Ar Black, WI | nerican Indian, nite, etc. |
| 36 | urs aft | þ | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, G 3 ☑ Widowed 4 ☐ Divorced Year or | 2 X No live Dates: | | 1 ☐ Yes 2 ☐XNo | Specify: | | Specify: W | hite |
| - 2 | 72 ho | Completed | 15. Decedent's Education (Specify only highest grade completed | (1) | 16a. Deced | dent's Usual Occup | ation | f workin a | 16b. Kind of Busines | ss/Industry |
| 2 | han a | mple | Elementary/Secondary (0-12) College | (1-4or 5+) | | DO NOT use retired | 1) | | Williams | huma Inn |
| N 0 | filed v Hygie Other t | | 07 n/ | a | | Waitre | | Name (First, Middle, | | burg Inn |
| aŭ | fental rked o | To Be | Franklin Moxley | | | | | via Baker | ŕ | |
| Maryland 21215-0036 | shou and M e mar | | 19a. Informant's Name/Relationship (Type, Print) | | 19b. Mailir | ng Address (Street | an <i>d Number</i> o | or Rural Route Numbe | er, City or Town, State | , Zip Code) |
| | s 1 and 2 should be filed within 72 hours after death with the Marylan if Healin and Mental Hygiene. If Healin and Mental Hygiene "naturat", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at | | Betty J. Dunham (Daug | No. of the last of | | Chathan | n Rd. | | , Maryla | |
| Baltimore, | Pages 1 ment of H ant: If ite ury or oth | | 20a. Method of Disposition 1 ☐ Meurial 2 ☐ Cremation 3 ☐ Removal from | n State Cerr | netery, crer | sition (Name of natory or other place | 106 | ec.01, | 20c. Location - City | |
| E | permit. Pages Department of Important: If it eny injury or o | 1 | 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License | Pal | | d Cem. | | -000 | | e,Maryland |
| Ba | permit. Departr Importa eny inj | | I Shen J. He | Wry Ps | E E | vans Fur | eral | Chapel&C | remation | Services 21234 |
| | | | 23a. Pand. Enter the disease, or complications that shock, or heart failure. List only one cause on | caused the death. | Do not ent | er the mode of dyin | g, such as car | rdiac or respiratory ai | rest, | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | promo | (ريا | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | o (or as a conseque | nce of): | | | | | |
| 90 | | 9 | Sequentially list conditions, if any, leading to immediate | o (or as a consequer | nce of): | | | | | |
| | day ansit | Examiner | Cause (Disease or injury that initiated events c. | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | |
| ó | ate be executed hysician and the burial-transit | | | o (or as a conseque | nce of): | | | | | |
| | ate be | dicai | d | | | | | | | |
| 9 × | The law requires that the death certifica lie has been signed by the attending ph page 2 should be detached for use as it | by Physician/Med | IF FEMALE: 23c, If yes, o | utcome of pregnanc | cv | | | | 23d Date of 6 | lolivoor |
| .O. Box | atten for u | clan | in the past 12 months? | birth 2 Fetal degrant at time of deal | eath 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of o Month | Day Year |
| Ö. | t the c by the tached | hys | 9 ☐ Unknown 9 ☐ Unk | nown | | | | | | |
| s, T | res tha igned be del | ру Р | Part II. Other significant conditions contributing to | death but not resulti | ing in the u | nderlying cause give | en in Part I. | | | to the cause of death? |
| ord | w require been si should I | eted | Parliner | | | | | | | Probably 4 Unknown |
| Records, | has b | Completed | CHF | | | | | — 24a. Was autor | an 24b. Were prior to death | autopsy findings available completion of cause of |
| a | | | 25. Was case referred to medical | | | | 00 Diago -f | 1 Tes | 2 No 1 Y | es 20 No |
| \equiv | yaiclan: Is certific director, | o Be | examiner? | Inpetient 2 EF | Q/Outpatier | t 3 DOA Oth | | Death (Check only on Home 5 Resident | dence 6 ☐Other (S) | pecify) |
| 0 | g Ph ierth ieral | T:uc | 27. Manner of Death 28a. Date (Mo | e of Injury 2: onth, Day Year) | 8b. Time of | | y at k? | | now injury occurred | |
| Sio | r Attendin er death. rector: Afi by the fur | catle | 2 Accident investigation | | | | Yes 2 □ No | | | |
| Division of Vital | | Certification: | determined 200 Place | ce of Injury - At hom ding, etc. (Specify) | e, farm, str | eet, factory, office | | City or Tox | Street and Number or vn, State) | Hural Houte Number, |
| | To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the | | 29a. Certifier 1 Certifying Physician: To the | ne best of my knowle | edge, death | occurred at the tin | ne, date and p | place, and due to the | cause(s) and manner | as stated. |
| | the Ho in 24 I the Fu | Medical | (Check only 2 Medical Examiner; On the one) and ma | basis of examination | n and/or in | | | occurred at the time, | date and place, and d | ue to the cause(s) |
| ı | To the within 2 To the complet | Σ | 29b. Signature and title of certifier | | | 29c. Licens | | | 29d. Date signed (Mo | |
| • | . 1 | | David 5 D | | 0-1 (** | | 2295 | | Nevember | 28,2001 |
| | H | | 30. Name and address of person who completed car DAVID DUNN - 615 W. N | use of death (Item 2 MACPHAIL I | | | IR, MD | . 21014 | | |
| 200 | Sta | te | 21 Date filed (Month Day Veer) 22 | Projetror's Signatur | | | | | | |
| | Registr | ar | NOV 2 9 2006 A | Cours & | A | | | | | |

06-08979 Derek Clark

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hydiene

| Serek Olark | 1-For State of Waryland / D1999000 Her Health and Wental Hyg Registrar #13,18319a Per FH G862 Certificate of Death | Reg. No. 2006 3777 |
|---|--|--|
| Physician/ | 1. Decedent's Name (First, Middle,Last) 2. | Date of Death Month Day Vear Vovember 25, 2006 3. Time of Death 1006 hrs |
| | 4a Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death | 4c. County of Death |
| | Parking lot of 2135 York Road Towson 5 Social Security Number 6 Sex 7 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8 | Baltimore County |
| Funeral Director | | Date of Birth(MM/DD/YYYY) 9 Birthplace (State or Foreign CountryMaryland |
| v any | 10a. State 10b. County 10c. City, Town or Location | 10d. Inside City Limits |
| yland -f shov once. | MD Baltimore Co. Cockeysville | 1 Yes 2 XNo |
| or death with the Maryland or items 23a or 28a-f sh must be notified at onc Funeral Director | 10e. Street and Number 67 Cherrywood Court 21030 | 10g Citizen of What Country? United States |
| nore, MD 21215-0036 ges I and 2 should be filed within 72 hours after death with the Maryland and of Health and Memal Hygiene it: If item 27 is marked other than "natural", or items 23a or 28a-f show any other transmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director | 11. Marital Status 1 Was Decedent Ever in U.S. 1 Wever Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Ric 1 Yes 2 No If Yes, Specify Cuban, Mexican, Puerto Ric 1 Yes 2 No If Yes, Specify Puers | an, etc) White, etc. |
| hours a | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work and during most of working life. DO NOT use retired) | |
| 5-0036 ed within 72 hour ed within 72 hour tygiene other than "natu the Medical Exan | Elementary/Secondary (0-12) 12 College (1-4 or 5+) n/a Customer Service | Starbucks |
| 21215-0036 uld be filed within 7 Mental Hygiene marked other than every, the Medica | 17 Father's Name (Mat. Madie, Last) 18 Mother's Name (Fin | st, Middle, Maiden Surname) |
| 1121 Id be fil Mental H narked event, | Edward Clifford Clark 19a. Informant's Net/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura | |
| e, MD 21215-00; I and 2 should be filed with Health and Mental Hygiene Titem 27 is marked other to r traumatic event, the Med | Edward C.Clark (Father) 67 Cherrywood Court | |
| re, re, rand frem frem frem frem frem frem frem frem | | ate 20c. Location - City or Town, State |
| 도 스 의 표 노 | 4 Donation 5 Other Specify: Evans Funeral Chapel | 2006 Forest Hill MD |
| Balti permit Departm Imports injury o | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Peaceful Alternat | ives Funeral&Cremation |
| Physicîan | 75/ P Leter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or restfulure. List only one caus in each line | spiratory arrest, shock, or heart Approximate Interval Between Onset and |
| /Medical Examiner | Immediate Cause (Final disease a. Narcotic intoxication | Death |
| | or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, b. | |
| iner | If any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause | |
| nsit Examiner | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) | |
| 760, icate be executed the burial - transit | X UNPENDED AMENDED 402 27 20 5 ME 000 10/0/00 FFF | |
| 760, Totate be executly physician and the burial - tra | #Z3a, Z/, Z8a-I, penylt, g8b2, 1Z/8/Ub II IF FEMALE. 23c. If yes, outcome of pregnancy | 23d Date of delivery |
| Sox 687 leath certific e attending province for use as the | 23b Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) | Month Day Year |
| Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as edical Certification: To Be Completed by Physician | 1 Yes 2 No 9 Unknown 9 Unknown | |
| P.O. E sthat the d | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I | 23e Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown |
| Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by Pertification: To Be Completed by P | | 24a. Was an 24b. Were autopsy findings available |
| Records, The law requires froze has been signate, page 2 should be Completed | | autopsy prior to completion of cause of death? |
| tal Reciriam: The liciam: The liciam: The liciam: Ector, page | 25. Was case referred to medical 26.Place of Death (Check only | 1 ✓ Yes 2 No 1 ✓ Yes 2 No one) |
| FVita Physici arthis cal To B | examiner? 1 Ves 2 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Ho | |
| n of rding Pth h: After e funeral | 27. Manner of Death 28a Date of Injury (Month, Day, Year) 1 Natural 5 Pending 28b Time of Injury 28c. Injury at Work? 28d 1 Yes 2 No | . Describe how injury occurred |
| livisior I or Attenc after death I Director: d in by the | 2 Accident Investigation Fnd 11/25/2006 Fnd 10:00 am X 1 | Inknown Location (Street and Number or Rural Route Number, City |
| Division or spiral or Attending averal after death rilled in by the fune. | Suicide A determined | or Town, State) 2135 York Road |
| he Hos in 24 hu he Fuu pletely | 29a Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the | to the cause(s) and manner as started |
| To the He within 24 To the Fi completel | and manner stated. 29b Signature and title of pertifier 29c. License number | 29d Date signed (Month, Day, Year) |
| | O.C.M.E. | November 26, 2006 |
| | 30 Name and address of p. on who completed cause of death (Item 23a) | |
| State | Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Monitoring Year) 2 2000 32. Registrar's Signature | |
| Registrar | 31. Date filed (Month Nov) (eg) 9 2006 32. Resistrar's Signature | |

Certificate of Death

Reg. No.

Day

Year

3. Time of Death

2. Date of Death

Month

Registrar

NOV 2 9 2006

OLMAN

For State Registra

1. Decedent's Name (First, Middle, Last)

06-08926 Vonzella Coates

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

| 2 | n | 6 | 3 | 7 | 7 | 7 | 1 |
|---|--------|--------|---|-----|-----|---|---|
| f | \cup | \cup | V | - 1 | - 1 | 8 | 0 |

| | | 1- For State Registrar | | Ce | rtificate | of | Death | | | F | Reg. No. | | 00 0111 |
|---|----------------|---|---|--|---------------|------------|---|----------------------|-------------|---------------|--|------------|---|
| Physicia Medical Exami | an/ | 1. Decedent's Name (First, Midd VONZELLA | coates | | | | | | | . Date of Dea | ath | Year | 3. Time of Death 1725 hrs |
| | | 4a. Facility Name (if not institution 2718 Bookert Drive | n, give street and n | umber) | | 4t | o. City, Town, or Brooklyn | Location o | of Death | | 4c. Cou N / A | nty of De | eath |
| Funeral Director | | 5. Social Security Number 216-78-5116 | 6. Sex | 7. Age (In yrs. I | ast birthday | /) Yrs. | If Under 1 Yea Months Day | | Min. | | rth(MM/DD/Y | Fo | Birthplace (State or reign Country) Md. |
| Maryland 28a-f show any d at once. | Director | | | 10c. City | Town or Lo | ti | more | | | | | | 10d. Inside City Limits 1 X Yes 2 No |
| death with the Maryland or items 23a or 28a-f sho | | 2718 Bookert | | | 0 140 | | | 225 | | | USA | | |
| | by Funeral | Lance Lance | arried Armed F 1 Yes orced If Yes, Give Ye or Dates: | 2 X No | 1 | If Yes | Decedent of His, specify Cubar Yes $2X$ No | n, Mexican, specify: | Puerto R | ican, etc.) | V Spec | Vhite, etc | Black |
| imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. | Completed | 15. Decedent's Education (Spe Elementary/Secondary (0-12) 12 | | 1-4 or 5+) | durin | ig mos | s Usual Occupa st of working life naker | | | | 16b. Kind o | | ss/Industry Homes |
| 5-0C ed with ygien other | 녌 | 17. Father's Name (First, Middle | Last) | | 11011 | 1011 | I | 18.Mother | s Name (F | irst, Middle, | Maiden Surna | | Homes |
| 21215-0036 Juld be filed within 7 Mental Hygiene, i marked other than ic event, the Medical | Be | Robert Will | iams | | | | | Gera | ıldi | ne S | cott | | |
| ould of Mer | 유 | 19a. Informant's Name/Relations | | | 19b. Ma | ailing / | Address (Stree | et and Num | ber or Ru | al Route Nu | mber, City or | Town, St | tate, Zip Code) |
| Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is mijury or other traumatic. | Į | Carol Partlo | w (Siste | | | | | | | | | | .21225 |
| re, land land land land land land land land | | 20a. Method of Disposition 1 X Burial 2 Cremation | 2 Demoval f | | Place of Dis | | ion (Name of ce er place) | metery, | | Date | 20c. Locati | ion - City | or Town, State |
| Baltimore, permit. Pages l ar Department of Hee Important: If ite | | 4 Donation 5 Other S | 1 | | dar H | [i1 | Cemet | erv | 11/: | 29/20 | 06Bro | okl: | vn.Md. |
| alti mit. partm ports ury o | - 1 | nature of Funeral Service | | (No. | | . Na | me and Addres | s of Facility | /- | inera | 1 Sor | vice | e, P.A. |
| E S E M | | work MX | off MI | avalle | 人和直 | al | timore | e. Mo | l. | 21217 | r per | V I C | е, г.н. |
| Physician | | a. Part I. Inter the discase, or failure. Iist only one cause | complications that o | caused the death | . To de en | ter the | mode of dying | such as ca | ardiac or r | | est, shock, or | r heart | Approximate Interval Between Onset and |
| /Medical Examiner | | Immediat ause (Final disease or condition resulting in death) | a. Methad | done intox | | n | | | | | | | Death |
| | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | b. Due to (or as | a consequence o | of): | | | | | | | | _ |
| executed an and Fe | Examiner | (Disease or injury that initiated events resulting in death) Last | d. | a consequence o | ή. | | | | | | | | |
| 4) 15 7 | edica | X UNPENDED | | #23a,27,2 | | perl | Æ, g862, | 12/11, | /06 TI | 1 | | | |
| Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physicinpletely filled in by the funeral director, page 2 should be detached for use as the buring | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Uni | 1 Live | outcome of preg birth nant at time of de nown | 2 | | al death 3 er (Specify) | Ectopic | : pregnanc | ey . | 23d. Date Mont | | very Day Year |
| P.O. I s that the gned by the e detache | | Part II. Other significant condit | ions contributing t | to death but not r | esulting in t | he un | derlying cause | given in Pa | rt I. | | | | to the cause of death? |
| S, P Lires th | q pe | | | | | | | | | | | | Probably 4 🗹 Unknown |
| Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stater death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach | Completed by | | | | | | | | | | osy rmed? | | autopsy findings available to completion of cause of 1? |
| Re ifficate | | 25. Was case referred to medica | | | | | 26 Place | e of Death (| Chook on | | 2 No | 1 🗸 | Yes 2 No |
| ital | Be | examiner? | Hospital: === | Inpatient 2 | ER/Outpat | ient | | Othor | Nursing I | | Residence | 6 2 0 | her Scene |
| Ing Phys After thi funeral d | 입 | 1 ✓ Yes 2 No 27. Manner of Death | | | 28b. Time | | | iry at Work | | | how injury oc | | ner, scerie |
| on on or or or or or or or or or or or or or | Ö | 1 Natural 5 Pend | all an ar | e of Injury h, Day,Year) | l | - | | Yes 2 v | No | | | | |
| Signature de la company de la | cat | 2 Accident Inve | stigation FIIC 289 Plan | 11/23/2006 ce of Injury - At h | | |) pin | Λ | | unknown | | imber or | Rural Route Number, City |
| Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the | Certification: | | d not be // (Specify, | | | | , , , | | | or Town, s | State) 271 | | okert Dr. |
| Hospi 24 hou Funer rely fil | | 29a Cartifier | hysician: To the be | | | ccurre | ed at the time, d | ate and pla | | | | nner as s | started. |
| To the Hos within 24 h To the Fur completely | Medical | one) 2 Medical Exa | miner:On the basis | of examination a | and/or inves | tigatio | on, in my opinior | n, death occ | curred at t | ne time, date | and place, ar | nd due ta | the cause(s) |
| To wit | ₽ | 29b. Signature and title of certific | | bidiod | | | 29c. Licens | se number | _ | | 29d. Date s | signed (/ | Month, Day, Year) |
| N) F | | Sancel Arall | III AM | | | | O.C. | M.E. | | | Novemb | er 24, | 2006 |
| 1.5 | | 30. Name and address of person | ho completed cau | use of death (Item | 1 23a) | | | | | | <u>. </u> | | |
| 1000 | | Pamela E. Southall, N | 15. | Medical Exa | , | 111 | Penn Stree | t, Baltim | ore, MD | 21201 | | | |
| S | ate | 31. Date filed (Month, Day, Year) | 32. | gistrar's Signati | | 1 | | | | | - | | |
| Regis | trar | NOV 2 9 | 2006 | Calica a l | 1 A | 284 | w | | | | | | |
| Danvin to Rev 172 | 001 | | | | ORIGI | NAL | | | | | | | |

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

| oarries ola | | | 1- For State Control of Thea Registrar Certificate of Dea | | Reg | No. 2001 | 3 3 7 7 7 |
|---|---|----------------|--|---|---|--|--|
| Ph Medical E | ysicia xami | | Decedent's Name (First, Middle,Last) James J.Ciarlante | | Date of Death Month November 2 | Pay Year 16, 2006 | 3. Time of Death 0725 hrs |
| | | | 4a. Facility Name (if not institution, give street and number) 4b. City, | , Town, or Location of Death | | 4c. County of Death | |
| Fur | neral | | | imore nder 1 Year If Under 24Hrs | s. 8. Date of Birth (| MM/DD/YYYY) 9. Birt | hplace (State or |
| | ector | | 211-58-5339 1 X M 2 F 43 Yrs. Mont | | | Foreig | |
| | v any | İ | 10a State 10b. County 10c City, Town or Location | | | | 10d. Inside City Limits |
| yland | 1-f sho | ğ | PA Montgomery Hatboro 10e Street and Number 10f. Zi | ip Code | 100 | . Citizen of What Coun | 1 X Yes 2 No |
| ith the Mar | 23a or 28 notified a | | 62 Home Road 190 | 040 | U. | .S.A. | |
| D 21215-0036 should be filed within 72 hours after death with the Maryland and Mernal Hveirene | from or regard and rotate trygione trait. If item 23 a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once. | Funeral | 1 Never Married 2 X Married Armed Forces? If Yes, spec | dent of Hispanic Origin? (Scify Cuban, Mexican, Puerto 2 X No specify: | | 14. Race - Americ White, etc. | |
| ours af | aturaľ | ğ D | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usua | al Occupation (Give kind of orking life. DO NOT use ret | | Specify: whit 6b. Kind of Business/Ir | |
| .036 vithin 72 h | r than "n Hedical E | Completed | Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driv | _ | · · | Trucking | |
| 21215-0036 und be filed within 7 | ed othe | - 1 | 17. Father's Name (First, Middle, Last) Nicholas A. Ciarlante | | e (First, Middle, Mai | , | |
| 212 ould be | s mark | | | ss (Street and Number or | na M. Pere | er, City or Town, State, | Zip Code) |
| e, MD and 2 sh Tealth an | em 27 i rauma | | Mary Beth Ciarlante / Wife 62 Home R | Road Hatboro | | Oc. Location - City or | Four State |
| Baltimore, MD permit. Pages 1 and 2 sh Department of Health and | Department of regard and property of other traumatic event, the Med | | 1 X Burial 2 Cremation 3 Removal from State Resurrection | 11- | -30-2006 | Bensalem, | PA |
| Balti permit. Departm | Import | - { | 2) Signature of Euneral Service Licentee 22. Name and 1 328 S | od Address of Facility Amb Sulphur Sprin | prose Fund | eral Home, | Inc. |
| Physi | | 1 | 23a. Part I. Enter the disease of complications that caused the death. Ed not enter the mode failure. List only one cause on each line. | | | | Approximate Interval Between Onset and |
| /Med Exam | | ı | Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of) | | | | Death |
| | | | Sequentially list conditions, b | | | | |
| | | Examiner | if any, leading to immediate cause Enter Underlying Cause (Unsease or in)ory that inflicted | | | | |
| executed | nd transit | | events resulting in death). Last Due to (or as a consequence of): d | | | | |
| | physician and the burial - transit | Medical | UNPENDED | | | | |
| 8760 , rtificate b | | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death | h 3 Ectopic pregna | ancy | 23d Date of delivery Month Da | ау Үеаг |
| Records, P.O. Box 68760, The law requires that the death certificate be | by the attending ached for use as | Physician | 4 Pregnant at time of death 5 Other (Special Yes 2 No 9 Unknown 9 Unknown | ecify) | | | |
| 0.0 . I | ned by tl detache | by Ph | Part II. Other significant conditions contributing to death but not resulting in the underlying | ng cause given in Part I. | | cco use contribute to the 2 No 3 Proba | |
| ' ds, l | this certificate has been signed I director, page 2 should be deta | | | | 24a Was an | 24b. Were auto | opsy findings available |
| ecor he law | ite has b ige 2 sh | Completed | | | autopsy performe 1 V Yes 2 | | empletion of cause of |
| | certifica ector, pa | Be | 25 Was case referred to medical examiner? | 26 Place of Death (Check | | | |
| f Vit | er this a | 욘 | examiner? 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 27 Manner of Death 28a. Date of Injury 28b. Time of Injury | DOA Other Nursir | ng Home 5 Re | sidence 6 Other | |
| on o | or: After the funeral | tion: | Natural 5 Pending Nov 26, 2006 0647 hrs | 1 ✓ Yes 2 No | | e motor vechicle | accident |
| Division of Vital Records, P.O. In the Hospital or Attending Physician: The law requires that the firm 24 hours after death | ral Direct | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Interstate/Express | y, office building, etc. | 28f. Location (Stre or Town, State I-95 S at Exit 59, | et and Number or Rure e) Baltimore, MD | al Route Number, City |
| To me Hosp within 24 hor | To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | ledical C | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at those only one) 2 Medical Examiner: On the basis of examination and/or investigation, in m | | | | |
| 77/23 | F 8 | Me | 29b. Signature and title of certifier 29 | 9c. License number | 29 | 9d Date signed (Moni | th, Day, Year) |
| | | | Celial Halory | O.C.M.E. | | November 26, 200 | 06 |
| | 2 | | 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, | Baltimore, MD 2120 | 1 | | |
| | | | 31. Date filed (Month, Day, Year) 32 Registrar's Signature | | | | |
| F | Regist | rar | NOV 2 9 2006 Selection 10 1 | | | | |

| F | | | | | ertificate of D | eatn | ntal Hygien Rag. N | | 01110 |
|---|---|-------------------|--|---|--|--|---|------------------------------------|---|
| | Physicia /Medic | an al | t. Decedent's Name (First, Middle, Last) | Coby | 4. 0. 7 | | lovember | 24,2006 | 3. Time of Death P |
| F | Examin uneral rector | 91 | 4a. Facility Name (If not institution, give sti 5. Social Security Number 6. Sex 214-86-8840 1 1 1 | HOSPICE 7. Age (h yrs. last birthda yrs. 39 Yrs. | 4b. City, Town, or L Bu 1 If Under 1 Year Months Days | MACE | Date of Birth Month, Day, Yea | 9. Birth | place (State or Foreign |
| vith the Maryland | or 28a-f show be notified at | Director | 10a. State 10b. County 10b. Street and Number | 10c. City, Town or Bal- | Location TMORE 10f. Zip Code | 2.5 | 10g. C | Citizen of What Cour | Od. Inside City Limits 1 Yes 2 No Nortry? |
| :1215-0036 within 72 hours after death with the Maryland ene. | el, or iteme 23s Examiner must | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 2. Was Decedent Ever in U.S. Armed Forces? 1 | 3. Was Decedent of Hiss If Yes, specify Cuban, | panic Origin? (Specif Mexican, Puerto Rin Specify: | fy Yes or No- can, etc.) | 14. Race - Americ Black, White, | |
| N pp | od other then "neture!" event, the Mudical Ex | e Completed | 15. Decedent's Education (Specify only highest grade) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) | completed) (Gi | cedent's Usual Occupative kind of work done du b. DO NOT use retired) | ion ring most of working . PING 8. Mother's Name (i | A | Kind of Business/In & T Arei | na TEA |
| Maryland od 2 should be file lith and Mental Hy | e marke | To Be | John Coby 19a. Informant's Name/Relationship Type | e. Print) (SISTER) 19b. Ma | ailing Address (Street an | Theody Id Number or Rural F | Oria Troute Number, City | Bannis vor Town, State, Zip | ter Code) |
| imore, Pages 1 ar | = = | | 20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) | moval from State Cemetery, c | sposition (Name of rematory or other place) | 12/2/9 | 2006 D | Location - City or To | own, State |
| Baltimore Pag | Impor eny in | | 21. Signature of Funeral Service Licenses 23a. Part / Enter the disease, or complic shoot, or heart failure. List only one | · Russ | 22. Name and Address 10 Seph Like 2222 W Nc enter the mode of dying. | ryss Fur | Balto. espiratory arrest, | ome P.A. | Approximate Interval Between |
| /M | sician edical iminer | | Immediate Cause (Final disease or condition resulting in death) | Due to (or as a consequence of): | | | | - A | Onseldend Death |
| 58760, icate be executed | physicien and s the burial-transit | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. | Due to (or as a consequence of): Due to (or as a consequence of): | | | | | |
| Box (death certif | led by the ettending p detached for use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | 3 □Ectopic pregnancy 5 □ Other (specify) | | | 23d. Date of delive Month | ery Day Year |
| Records, P.O. | been signed t should be det | þ | Part II. Other significant conditions cont | nbuting to death but not resulting in the | e underlying cause given | in Part I. | 1 ☐ Yes | | ably 4 Dunknown |
| | is certiticete hes l director, page 2 s | Be Completed | 25. Was case referred to medical examiner? | CNS lym | phom | 26. Place of Death (| 24a. Was an autopsy performed? 1 Yes 2 Check only one) | prior to condeath? | psy findings available mpletion of cause of |
| Division of Vita | After this funeral di | Certification: To | 1 Yes 2 No Ho 27. Manner of Death t Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be | ospital: 1 ☐ Inpatient 2 ☐ ER/Outpat 28a. Date of Injury (Month, Day Yee/) 28b. Time Injur | e of 28c, Injury a Work? M 1 \(\text{Y} \) | at 28 | d. Describe how in | | |
| DIVI To the Hospital or At | To the Funeral Director: completely tilled in by the | | 4 Homicide determined 29a. Certifier (Check only 2 Medical Examin. | 28e. Place of Injury - At home, farm, building, etc. (Specify) cian: To the best of my knowledge, deer: On the basis of examination and/or | eath occurred at the time | , date and place, an | City or Town, Sta | (s) and manner as s | tated. |
| To the P | To the I | Medical | 29b. Signature and title of centiler | and manner stated. | 29c. License | | | Date ligned (Month) | |
| | 5 Sta | ite | 30. Marrie and address of person who con 31. Date filed (Month, Pay, Year) NOV 2, 9, 2006 | hpleted cause of death (Item 23a) (Typ | pe, Print) | 81 F41 | 40, M | 1212 | 18 |

| | | State Registrar | | | Cer | tificate of I | Death | | | Reg. No. U | U6 | 3/1/5 |
|--|-------------------|--|--|--------------------------------|--------------------------|--|--|-------------------------------|------------------------------|------------------------------|---------------------------------------|--|
| Physician | 1 | Decedent's Name (First, Middle, GENY A | | | CH | ECHIK | | | Date of De | ER ^D 26, | 2006 | 3. Time of Death 1:50 P M |
| /Medica Examine | | 4a. Facility Name (If not institution, g | | CENTER | 2 | 4b. City, Town, or | | TOWSO | ٧ | 4c. Cour | ity of Death BAL | .TIMORE |
| Funeral Director | | 213-35-0156 | i. Sex 1 ☐ M 2 ☐ F | e (In yrs. last 83 | Vrs. | Months Days | If Under Hours | | Date of Bird | 1923 | 9. Birthp Cour | BELARUS |
| e Maryland la-f show tifled at | | Usual Residence of Decedent | MORE | 10c. City, To | IMOR | | | | | | 1 | 0d. Inside City Limits 1 ☐ Yes 2 No |
| ifter death with the Mar r ftems 23a or 28a-f st ilner must be notified | al Dire | 10e. Street and Number 2152 CHARLES HE | ENRY LANE | | | 10f. Zip Code | 2120 | 9 | | 10g. Citizen o | f What Cour | usa USA |
| al', o | 2 | 11. Marital Status 1 □ Never Married 2 □ Married 3 🛣 Widowed 4 □ Divorced | 12. Was Decedent I Armed Forces? d 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates: | | | /as Decedent of H Yes, specify Cuba ☐ Yes 2【X No | ispanic Ori an, Mexicar Specify: | | y Yes or No can, etc.) | Spec | ace - Americ lack, White, cify: | |
| within 72 h iene. • than "natu the Medical | Completed | 15. Decedent's (Specify only highest Elementary/Secondary (0-12) | Education grade completed) College (1-4or 5 | | (Give k life. D | ent's Usual Occup ind of work done o O NOT use retired I CIAN | ation during mos 1) | t of working | | MEDIC | | dustry |
| Mental Hyg Mental Hyg arked other atic event, i | a a | 17. Father's Name (<i>First, Middle, Le</i> MOTLE | ast) | <u>'</u> | CHEC | | S0 | NYA | | Maiden Surn | KAR | ROLINSKY |
| and 2 sho ealth and n 27 Is m | | 19a. Informant's Name/Relationship IZABELLA RAKHUN | | ΓER | 3204 | OLD POS | | VE #11 | l – BA | LTIMOR | E, MD | 21208 |
| Pages 1 ment of H ant: if iter ury or oth | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe | | ceme | etery, crem | ition <i>(Name of</i> atory or other plac CHIZUK Al | | Date 11/28/ | | 20c. Location | TIMORE | |
| permit. Departimporti | | 21. Signature of Funeral Service Li | censee | | | Name and Address | | SOF | | NSON & PIKESV | | , INC. MD 21208 |
| Physician /Medical Examiner | | 23a. Part1. Enter the disease, or conshock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) | omplications that caused nly one cause on each lir a. Due to (or as | IS | o not ente | r the mode of dyin | ig, such as | cardiac or r | espiratory a | rrest, | | Approximate Interval Between Onset and Death |
| certificate be executed ding physician and C ise as the burial-transit | Ехаш | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as d. | | e of): | r car | | | 9 | | | |
| w requires that the death certificate be execu been signed by the attending physician and should be detached for use as the burial-tra | Pnysician/medical | IF FEMALE: 23b. Was decedent pregrant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome 1 □Live birth 4 □Pregnant at 9 □Unknown | 2 Fetal dea | ath 3□ | Ectopic pregnancy Other (specify) | , | | | | Date of delive | ery Day Year |
| uires that signed by | _ ⊆ | Part II. Other significant condition | s contributing to death be | ut not resulting | g in the un | derlying cause giv | en in Part I | | 23e. Did to | | | ne cause of death? |
| 2 2 3 | Completed | | | | | | | | 1□ Yes | osy ormed? 2 No | prior to con death? | psy findings available mpletion of cause of 2 Mo |
| thysician this certifi al director | 0 0 | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No | Hospital: | ent 2 ER/e | Outpatient | 3□ DOA Oth | or. | | Check only o | one) dence 6 □C | ther (Specif | i/) |
| To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page | | 27. Manper of Death 1 1 Natural 5 Pending 2 Accident investiga | 28a. Date of Inju (Month, Day | ry 28t | o. Time of Injury | 28c. Injur Worl | | 280 | | how injury occi | | <u>//</u> |
| tal or Atters all Directo | Certification: | 3 ☐ Suicide 6 ☐ Could no determin | t be ed 28e. Place of inju- building, etc | ury - At home, c. (Specify) | farm, stre | et, factory, office | | 28f | Location (S City or Tov | Street and Nur vn, State) | nber or Rura | Il Route Number, |
| he Hospit in 24 hour he Funer pletely fills | Medical | 29a. Certifier 1 ☐ CertifyIng (Check only one) 2 ☐ Medical E. | Physician: To the best of xaminer: On the basis of and manner sta | f examination | dge, death and/or inv | occurred at the tir estigation, in my o | ne, date an ppinion, dea | nd place, and ath occurred | d due to the at the time, | cause(s) and i | manner as s e, and due to | lated. > the cause(s) |
| To t To t | 2 | 29b. Signature and title of certifier Cyptus 9 | Smaur | W | | 29c. Licens | | 347 | _ | 29d. Date sign | 27 / | Day, Year) |
| 3 | | | auo MD | 6701 | NIC | harles. | St E | Ba141 | more | MD | 2120 | 14 |
| State Registra | | 31. Date filed (Month, Day, Year) NOV 2 9 2 | 006 Electron | ar's Signature | Span | W | | | | | | |

DHMH 17 Rev 1/2001

06-08905 John Cureton

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2006 37777

| | | 1- For State Registrar | | rtificate of D | eath | | Reg. No. 200 | 6 3777 |
|---|----------------|--|---|--|---|--|--|---|
| Physic Medical Exam | | OUTT LL | ireton | | | 2. Date of De Month Novembe | ath Day Year er 23, 2006 | 3. Time of Death 0035 hrs |
| | | 4a. Facility Name (if not institution, University Hospital | give street and number) | | ity, Town, or Location o altimore | f Death | 4c. County of Deat | 4 |
| Funeral Director | | 611 25 -000 | Sex 7. Age (In yrs. law) XM 2 F 4 | | Under 1 Year If Under Ionths Days Hours | | , Teoreia | thplace (State or gn buntry) |
| ie Maryland or 28a-f show any | tor | 10a. State 10b. County | | Town or Location | | | | 10d. Inside City Limits 1 X Yes 2 No |
| death with the Maryland or items 23a or 28a-f sho must be notified at once | al Director | 3156 Elm | ora Ave. | | 21213 | | 10g. Citizen of What Cou | ntry? |
| after death w al", or items ner must be | by Funeral | 11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorce | 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Pales: | If Yes, s | cedent of Hispanic Origi pecify Cuban, Mexican, 2 No specify: | | 14. Race - Amer White, etc. | can Indian, Black, |
| AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiens 7 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once | ompleted b | 15. Decedent's Education (Specify Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. Decedent's U during most o | sual Occupation (Give k f working life, DO NOT u | ind of work done use retired) | 16b. Kind of Business/ | Marrietta |
| 21215-0036 Jd be filed within 72 Mental Hygiene. narked other than 'event, the Medical | o Be Cor | 17. Father's Name (First, Middle, La | Cureton | Sr. | Aug | Name (First, Middle, | Maiden Surname) | |
| and and fealt frau | T | 19a. Informant's Name/Relationship 20a. Method of Disposition | Martin 200. P | 19b. Mailing Add 3156 Place of Disposition | Elmora (Name of cemetery | Ave. P | mber, City or Town, State | 21213 |
| altimor mit Pages partment of portant: If | | 1 Surial 2 Cremation 4 Donation 5 Other Spec 2 Signature of Funeral Service Liq | ify: | | and Address of Facility | 12/5/2006 | 4. | IK, Md. |
| 四 混合 里宝 Physician /Medical | | 23 / Part I. Enter the disease, or co- lailure. List only one cause on | if Ilications that aused the death. I each line. | 12222 | - W. North | AVE. 2 | al Home, faulto, Marest, shock, or heart | Approximate Interval Between Onset and |
| Examiner | | Immediate Cause (Final disease or condition resulting in death) | a. Head injuries with Due to (or as a consequence of) | | tions | | | Death |
| | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | Due to (or as a consequence of) |): | | | | |
| ecuted and transit | I Examine | (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of) |): | | | | |
| 760, cate be exe physician the burial - | n/Medica | ☑ UNPENDED [| AMENDED #23a,27,28 | Ba-f, perME. | g864, 2/2/07 | T | Load Data of dations | |
| lecords, P.O. Box 68760, The law requires that the death certificate be executed are has been signed by the attending physician and age 2 should be detached for use as the burial - transi | Physician/ | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow | 1 Live birth Pregnant at time of dea | 2 Fetal de | | pregnancy | 23d. Date of delivery Month D | ay Year |
| P.O. res that the signed by the detache | ρ | Part II. Other significant conditions | contributing to death but not res | sulting in the underl | ying cause given in Part | | bacco use contribute to t | |
| DZ [.2 A] | Completed | | | | | 24a. Was autop perfor 1 • Yes | sy prior to co med? death? | opsy findings available ompletion of cause of |
| 1 of Vital Jing Physician: After this certiff | Be | 25. Was case referred to medical examiner? 1 VYes 2 No | Hospital: 1 | ER/Outpatient 3 | 26 Place of Death (C | | Residence 6 Other. | |
| _ = ^ = 1 | ation: To | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe h | now injury occurred | |
| Division To the Hospital or Attendin within 24 hours after death To the Funeral Director: A completely filled in by the fu | Certification: | 3 Suicide 6 X Could no determin | ot be 28e. Place of Injury - At hon | | ory, office building, etc. | | | al Route Number, City |
| To the Ho within 24 To the Fu completely | Medical | one) 2 Medical Examin | cian: To the best of my knowledge er:On the basis of examination and and manner stated. | e, death occurred at d/or investigation, in | the time, date and place my opinion, death occu | e, and due to the cause irred at the time, date a | and place, and due to the | cause(s) |
| | Σ | 29b. Signature and title of certifier | M. 16 | | O.C.M.E. | | November 23, 200 | |
| | | 30. Name and address of person who Jack Titus MD. Deputy | completed caus of death (Item 2 Chief Medical Examiner | | reet, Baltimore, M | D 21201 | | |
| St Regist | ~~ | 31 Date filed (Month, Day, Year) | 32. Pigistrar's Signature | fich | , | | | |

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 006

| 3 | 7 | 7 | 7 | 8 |
|---|---|---|---|---|
| | - | - | | |

| | Physician |
|-------------|-----------|
| | /Medica |
| <i>></i> | Examine |
| | |
| _ | |

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Itema 23a or 28a-f ehow my Injury or other traumatic event, the Madical Examiner must be nutified at once.

9:20 р.ш.

NOVEMBER 27, 2006

JAMES CROGAN

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Madical Certification: To Be Completed by Divisional Madical Eventing

| | 1 - State Registrar | | rtificate of Death | Reg. | No. | | | |
|---|---|---|---|--|---|--|--|--|
| ın | Decedent's Name (First, Middle, Last) JAMES XAVIE | | | 2. Date of Death Month November | ^{Day} 27,2006 | 3. Time of Death 9:20P | | |
| al er | 4a. Facility Name (If not institution, give s Stella Maris Hospi | | 4b. City, Town, or Location of Death | | 4c. County of Death | h | | |
| | 5. Social Security Number 6. Sec. 212-20-2822 XX | 7. Age (In yrs. last birthday, | If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Ye ebruary 24, | 9. Birti 1926 Mary | nplace (State or Foreig unity) yland | | |
| _ | 10a. State 10b. County | 10c. City, Town or L | | | | 10d. Inside City Limits | | |
| recto | Maryland Baltimor 10e. Street and Number | e Parkville | 10f. Zip Code | 100 | Citizen of What Co | 1 ☐ Yes XX N | | |
| | 8503 Dempster Cour | t Apt C | 21234 | , og. | USA | unity: | | |
| To Be Completed by Funeral Director | 11. Marital Status 1 Never Married 2XXMarried 3 Widowed 4 Divorced | 12. Was Decedent Ever in U.S. Armed Forces? 1 XVes 2 No WWII If Yes, Give Year or Dates: | Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes ※ No Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Amer Black, White Specify: | | | |
| sieted | 15. Decedent's Edu (Specify only highest grade | e completed) (Give | dent's Usual Occupation h kind of work done during most of work DO NOT use retired) | rin g 16b | . Kind of Business/I | ndustry | | |
| E O | Elementary/Secondary (0-12) | College (1-4or 5+) | memical Operator | | Paint | | | |
| Bec | 17. Father's Name (First, Middle, Last) | | | e (First, Middle, Maid | den Sumame) | | | |
| ္ | Edward Daniel Crog | | | Barrett | | | | |
| | 19a. Informant's Name/Relationship (Ty, James X Crogan Jr | Son 7 Rav | ng Address (Street and Number or Rur Vens Nest Court Gl | en Arm Mar | yland 210 | 057 | | |
| | 20a. Method of Disposition 1XXBurial 2 Cremation 3 R | emoval from State | matory`or other place) | | . Location - City or | | | |
| 1 | □ Donation 5 □ Other (Specify) 21 Signature of Funeral Service License | A | ley Memorial 12/ 2. Name and Address of Facility Mito | | monium Ma | | | |
| | Donnis Syst | an/Xonake | 6500 York Road | | | | | |
| Completed by Physician/Medical Examiner | Sequentially list conditions, if any, Isaumy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | |
| ysician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | | | | | | | |
| ed by Ph | Part II. Other significant conditions con- | ntributing to death but not resulting in the u | nderlying cause given in Part I. | 23e. Did tobacc | co use contribute to | the cause of death? | | |
| Complet | | | | 24a. Was an autopsy performed 1 ☐ Yes 2 🛣 | prior to co | opsy findings available omptetion of cause of 2 No | | |
| Be | 25. Was case referred to medical examiner? | lospital: | Others | h Check only one | | | | |
| ation: 10 | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury | 1 3 DOA 4 Nursing Ho | me 5 Residence 28d. Describe how in | | (ty) HOSPICE | | |
| ertific | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At home, farm, st building, etc. (Specify) | reet, factory, office | 28f. Location (Street City or Town, St. | and Number or Rui ate) | ral Route Number, | | |
| Medical Certification: | 29a. Certifier (Check only one) 1X Certifying Physical Examination (Check only one) | sician: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated. | h occurred at the time, date and place, vestigation, in my opinion, death occur | and due to the cause red at the time, date a | e(s) and manner as and place, and due | stated. to the cause(s) | | |
| ž | 29b. Signature and title of certifier | | 29c. License number | 1 | Date signed (Month, | , | | |
| | | 12. | D43725 | | 11/28/06 | • | | |
| | M | mpleted cause of death (Item 23a) (Type, | · | | | | | |
| e | DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year) NOV 2 9 2006 | 2300 DULANEY VALLI 32. Registrar's Signature | | MD 21093 | | | | |

ORIGINAL

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** November 26, 2006 15:50 Dieter Sr. Fox Harry /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Johns Hopkins Bayview Medical Center Baltimore City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1**X** M 2□ F Maryland Director 214-26-4053 July 25,1929 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3487 Dunhaven Road 21222 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify:White 1 ☐ Yes 2 No Specify: ģ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 12 years Ironworker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Fox Bissell Joseph M. Dieter Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3485 Dunhaven Road, Dundalk, Maryland 21222 Daughter Dawn M. Dieter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory Baltimore City, MD. 29, 2006 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. 21. Signature of Fuheral Service Licensee 11. Enter the dis as , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** I NEU MONIA /Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions, if any, leading to immediate cause Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): lospital or Attending Physician: The law requires that the death certificate be executed hours after death.

'uneral Director: After this certificate has been signed by the attending physician and sly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c, If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No 3 Probably 4 Unknown DIABETES Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PULMONARY HYPERTENSION autopsy perform 2 ☐ No 1 ☐ Yes 1∐ Yes 210 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) RES GOO 30. Name and ad test of person who completed cause of death (Item 23a) (Type, Print) 10 EASTERN AVENUE BALTIMORE, MD GREGGOR 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene2006Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D26, 2006 Physician ETHEL DEAVER November 9:40P WILDE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Presbyterian Home of Maryland Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M XXF 109 215-40-4399 September 17,1897 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itama 23s or 28s-1 show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 Maryland Baltimore **Funeral Directo** Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 400 Georgia Court USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes ANNO Specify: ģ X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edwin Wilde Addie Mae Pitts permit. Pages 1 and 2 sho Department of Health and Important: If Itam 27 is my eny injury or other traum 900.9. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Deaver Walker DTR 1474 South Sandbar Road Kankakee Illinois 60901 20a. Method of Disposition

*XXBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Bee Tree Cemetery 11/30/06 □Donation 5 □ Other (Specify) Parkton, Maryland Signature of Funeral Service Ligense 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 XII GUU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) neumonia **Physician** one week /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transif Due to (or as a consequence of): Physician/Medical as ed by the aftending I detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown as been signed by 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Unknown 1 Yes 2 No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No has After this certificate 28 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 1 Yes 2 No Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

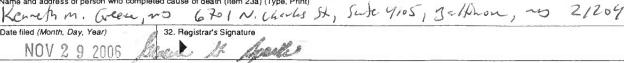
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



Attending mo

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

0370/6

29d. Date signed (Month, Day, Year)

November 27, 2006

| | | | 1 - For State Registrar | State of Maryland / De | epartment of Health an Certificate of Death | | giene Jeg. No. 2005 | 37781 |
|-------------|--|------------------|--|---|---|--|---|--|
| | Physici | an | 1. Decedent's Name (First, Middle, Last) Thomas Davis | > | | 2. Date of Dea Month | Day Year | 3. Time of Death |
| 3 | /Medic Examir | | 4a. Facility Name (If not institution, give s | | 4b. City, Town, or Location of D | eath | 4c. County of Death | 12:50AM |
| | | | <u> </u> | spice | Timonium | <u>) </u> | Baltir | |
| I | Funeral Director | | 5. Social Security Number 6. Sex 124 · 20 · 6334 | 7. Age (In yrs. last birthe | Months Days Hours N | fin. 8. Date of Birth (Month, Day | y Year) 9. Birthp Coun | lace (State or Foreign |
| | P | | Usual Residence of Decedent 10a, State 10b, County | 10c. City, Town o | or Location | | | Od Jacida City Limita |
| | Maryla f ahov | ō | MD N/A | | altimore | | | 0d. Inside City Limits 1 |
| | or 28a | Funeral Director | 10e. Street and Number | | 10f. Zip Code | 1 | l 0g. Citizen of What Cour | itry? |
| | s 23s | ral | | Park Alenue | 21213 | 1/0 | USA | an Indian |
| 21215-0036 | is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23s or 28s-f ahow other traumatic event, the Medical Examinar must be notified at | þ | 11. Marital Status 1 1 □ Never Married 2 □ Married 3 State Midowed 4 □ Divorced | 2. Was Decedent Ever in U.S. Armed Forces? 1 | 13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P 1 □ Yes 2 No Specify: | Jerto Rican, etc.) | 14. Race - Americ Black, White, Specify: Bl | |
| 15-(| n 72 h "natu edicel | lete | 15. Decedent's Educ (Specify only highest grade | ation 16a. D | ecedent's Usual Occupation Give kind of work done during most of ife. DO NOT use retired) | working | 16b. Kind of Business/Inc Bethlehen | • |
| 212 | d withi | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | Steel Worker | | Steel Cor | • |
| | be filed htal Hygi od other event, II | To Be C | 17. Father's Name (First, Middle, Last) | , | | Name (First, Middle, | | |
| Maryland | 2 should be and Mental is marked o | မ | JOHN DAVIS 19a. Informant's Name/Relationship (Type | e, Print) 19b. N | Mailing Address (Street and Number 6 | | r, City or Town, State, Zip | Code) |
| | 1 and 2 Health a om 27 is | | Katie Davenport | Friend 87 | 10 Mission Road | Jessup M | _ | |
| lore | D 0 | | 20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐ Re | MIOVALITOITI STATE | isposition (Name of crematory or other place) | | 20c. Location - City or To | _ |
| Baltimore, | permit. Page Department o Important: If any injury or once. | | 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License | Arbutu | | | Baltimore | , MD |
| Ba | Depa Impo any i | | Baclat | M01363 | Agustin C. Greene | Baltimore | MO 21212 | |
| ı | | | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on | ations that caused the death. Do no a cause on each line. | t enter the mode of dying, such as car | diac or respiratory arr | est, | Approximate Interval Between Onset and Death |
| 1 | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | ADRENAL CANCER Due to (or as a consequence of) | | | | onsor and bount |
| | Examiner | | Sequentially list conditions | | | | | |
| 17 | ted nsit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequence of) | : | | | |
| v o | be executed siclen and burial-transit | | that initiated events c. resulting in death) Last | Due to (or as a consequence of) | : | | | |
| 8760, | rtificate be ng physicie as the bu | dical | L d | | | | | |
| P.O. Box 68 | Physician: The law requires that the death certificate be executed this certificate hes been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit | by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown | 3 □Ectopic pregnancy 5 □ Other (specify) | | 23d. Date of delive Month | ry Day Year |
| ٠, ص | s that med by e deta | y Ph | Part II. Other significant conditions con | ributing to death but not resulting in t | he underlying cause given in Part I. | 23e. Did to | bacco use contribute to th | e cause of death? |
| ord | w require been sig should b | | | | | _ 1 U Y | es 2□No 3□Prob | ably X Unknown |
| Records, | hes b | Completed | | | | 24a. Was a autops perform | sy prior to cor | psy findings available apletion of cause of |
| tal | ding Physician: The lav h, After this certificete hes funeral director, page 2 | 0 | 25. Was case referred to medical | | 26 Place of | 1 ☐ Yes Death / Check only or | 2 XNo 1 ☐ Yes | 2□ No |
| of Vital | hysici his cer il direc | To B | | ospital: 1 ☐ Inpatient 2 ☐ ER/Outp | atient 3 DOA Other: 4 Nursin | | ence 6 Other (Specify | HOSPICE |
| | Jing After fune | tlon: | 27. Manner of Death 1 Note Note 1 | 28a. Date of Injury (Month, Day Year) 28b. Tin | | 28d. Describe ho | ow injury occurred | |
| Division | or Atten ifter deat Sirector: in by the | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At home, farm building, etc. (Specify) | | 281. Location (Si City or Town | treet and Number or Rura n, State) | l Route Number, |
| | Hospit 4 hour Funara ely fille | ical | 29a. Certifier 1X Certifying Phys (Check only 2 Medical Examin | cian: To the best of my knowledge, on the basis of examination and/ | death occurred at the time, date and por investigation, in my opinion, death of | ace, and due to the c | ause(s) and manner as st | ated. the cause(s) |
| | To the Hospital within 24 hours a To the Funaral Completely filled | Medical | one) 29b. Signature and title of certifier | and manner stated. | 29c. License number | | 9d. Date signed (Month, | |
| | F \$ F 0 | | 1- | | D437 | 210 | 11/22 | 106 |
| | 6 | | 30. Name and address of person who con | npleted cause of death (Item 23a) (Ty | ype, Print) | | | |
| | Sta | ite. | DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year) | 2300 DULANEY VA | | MD 2109 | 3 | |
| 4 | Registi | | NOV 2 9 200 | 32. Degistrar's Signature | horall o | | | |
| DHI | MH 17 Rev 1/2 | 001 | | • | IGINAL | | | |
| | | | | On | OHAL. | | | |

NOVEMBER 22, 2006

THOMAS DAVIS

| Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10d. Zip Code 10d. Zip Code 10d. Zip Code 10d. Citizen of What County 11d. Marital Status 11d. Marital Status 11d. Never Married 12d. Was Decedent Ever in U.S. Armed Forces? 11d. Never Married 11d. Never M | 3. Time of Death (1): 0 2 PM Illace (State or Foreign |
|--|---|
| GOOD SAMAIZITAN HOSP ITAL BALTIMORE NIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Wonths Days Hours Min. Wonth, Day, Year) Wonth, Day, Year) Usual Residence of Decedent GOOD SAMAIZITAN HOSP ITAL BALTIMORE NIA NIA 1 | place (State or Foreign |
| Usual Residence of Decedent | |
| 109. Street and Number 109. Street and Number 109. Street and Number 109. Street and Number 109. Street and Number 109. Street and Number 109. Citizen of What Cour 109. Citizen of What Cour 109. Citizen of What Cour 109. Citizen of What Cour 109. Citizen of What Cour 109. Citizen of What Cour 109. Citizen of What Cour 109. Citizen of What Cour 109. Citizen of What Cour 109. Citizen of What Cour 109. Citizen of What Cour 109. Citizen of What Cour 109. Citizen of What Cour 109. Citizen of What Cour 119. Marital Status 119. Mary Beach, White, 119. Specify: 119. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Specify: 119. Specify: 119. Marital Status 129. Marital Status 139. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, Specify: 14. Race - Americ Black, White, 159. Decedent's Education (Specify: 140. Specify: 150. Decedent's Education (Give kind of work done during most of working life. Do Not use retired) 150. Kind of Business/Inc 151. Decedent's Name (First, Middle, Maiden Sumame) 152. Decedent's Education (Specify: 153. Decedent's Usual Occupation (Give kind of work done during most of working life. Do Not use retired) 153. Mary Black, White, 154. Race - Americ Black, White, 155. Decedent's Education (Specify: 150. Kind of Business/Inc 161. Kind of Business/Inc 162. Kind of Business/Inc 163. Mary Black, White, 164. Race - Americ Black, White, 165. Kind of Business/Inc 166. Kind of Business/Inc 167. Kind of Business/Inc 168. Kind of Working life. Do Not use retired) 169. Kind of Working life. Do Not use retired) 160. Kind of Business/Inc 160. Kind of Business/Inc 160. Kind of Business/Inc 161. Race - Americ Black, White, 162. Specify: 164. Race - Americ Black, White, 165. Kind of Business/Inc 166. Kind of Business/Inc 167. Kind of Business/Inc 168. Kind of Business/Inc 169. Kind of Working life. Do Not use retired) 169. Kind of Working life. Do Not use retired) 169. Kin | 0d. Inside City Limits 1 √ es 2 √ No |
| The property of the property o | ntry? |
| The state of the s | nite |
| 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 570/ 6.51/ | |
| 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Total Cemetery, crematory or other place) | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Name and Address of Facility 24. Signature of Funeral Service Licensee 25. Name and Address of Facility 26. Location - City or Tot Cemetery, crematory or other place) 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Fac |), |
| 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death |
| Sequentially list conditions, if any, leading to immediate b. PULSELESS ELEGRICAL ACTIVITY ARREST Due to (or as a consequence of): | |
| IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of deliver | y Day Year |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the DIAILETES 1 Yes 2 No 3 Proba | |
| DIAILETES Section Probati | sy lindings available pletion of cause of |
| To be 1 yes 20 No Pending 1 Pending 2 ER/Outpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 3 Control 1 Pending 28d. Describe how injury occurred | |
| | |
| 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, D. | he cause(s) |
| ISALIM BAGHLI MID 14) RES 000 NOV 26 | 2006 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type Print) SALIM PAGHLI GOOD SAMAZITAN HOWATAL PALT, MORE - MID State 31. Date liled (Month: Day, Year) Registrar 12. 9 2006 | LVD |

DHMH 17 Rev 1/2001

FOXWELL

State of Maryland / Department of Health and Mental Hygiene U U 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 1:05 A M 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore medical Certer 15altimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2□ F 217-50-4012 Usual Residence of Decedent 02/16/1948 Director MARYIAND 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Hygiene. other than "natural", or Items 23s or 28s-1 show rent, the Madical Examiner must be notitied at 1 Yes 2 No BALTIMORE Completed by Funeral Directo MARYLAND 10e. Street and Number 10g. Citizen of What Country? U.S.A. 2/2/8 12. Was Decedent Ever in U.S. Armed Forces?

Daryes 2 \(\triangle \text{No} \) 1968
If Yes, Give
Year or Dates: 1974 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOME IMPROVEMENT LABORER 12 17. Father's Name (First, Middle, Last) and Mental RALPH FRANKLIN SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/8 729 /2 ARGONNE DRIVE BALTIMORE MARYIAND
Date 20c. Location - City or Town, State /SISTER f Health item 27 i GENEVA FRANKLIN 20a. Method of Disposition 12/05/2006 OWINGS MILLS, MARYLAND 1 Burial 2 □ Cremation 3 □ Removal from State GARRISON FOREST COME. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ThE DERRICK C. JONES FIH
PA., 4611 PARK HEIGHTS AUR., BALT, MORE
MARYLAND 21215 21. Signature of Funeral Service Licer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Ar Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dus to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Medicai Certification: To Be Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Natural

2 Naccident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 N. Greene Street, Baltimore,

DHMH 17 Rev 1/2001

State Registrar

Michael 31. Date filed (Month, Day, Year)

NOV 2 9 2006

32 Registrar's Signature

06-09017 Sa

Please Type or Print in Black Indelible Ink

| diq Foreman | | State of Maryland / Department 1-For State | | 000 | C 0770 |
|---|----------------|---|--|---|--|
| Physici | | Registrar | | Reg No. 2. Date of Death | 3 Time of Death |
| edical Examiner | | 101011 | | November 26, 2006 | 1703 hrs |
| | | 4a Facility Name (if not institution, give street and number) St. Agnes Hospital | 4b. City, Town, or Location of Death Baltimore | 4c. County of Death | 1 |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday | (r) If Under 1 Year If Under 24Hrs. | | thplace (State or |
| Director | | 150-82-1522 10M 2XF 33 | Yrs Months Days Hours Min. | Oct 23/973 Foreig | untry) Tecsey |
| х. | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo | | <u></u> | 10d Josido City Lysias |
| _ 0w an | | 10a. State 10b. County 10c. City, Town or Lo | ocation . | | 10d Inside City Limits 1 Yes 2 No |
| ıryland 3a-f sh at once | ctor | 10e. Street and Number | 10f. Zip Code | 10g Citizen of What Coul | |
| the Ma a or 28 | Director | 6 South St | 07901 | 115 | À |
| n with ms 23. | eral | | Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto | | ican Indian, Black, |
| er deatl | Funeral | 1 Yes 2 No | | DI | ack |
| ırs afte tural", | l by | 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a Dece | Yes 2 No specify edent's Usual Occupation (Give kind of w | vork done 16b Kind of Business/I | Industry |
| 72 hou n "nat | Completed by | | g most of working life. DO NOT use retir | red) | 1 |
| 0036 within iene er tha Medic | lduc | 12 2 1 | Inemployed | a N/ | + |
| Baltimore, MD 21215-0036 permit Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Memal Hygiene Important: If time X7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Be Co | 17. Father's Name (First, Middle, Last) | 18.Mother's Name | (First, Middle, Maiden Surname) | 1000 |
| 212 212 Ould be Ments mark c even | lo B | 19a. Informant's Name/Relationship (Type, Print.) 19b. Ma | ailing Address (Street and Number or R | Rural Route Number, City or Town, State | , Zip Code) |
| MD d 2 she lth and n 27 is | ľ | Mr. Lawrence toreman 6 | South St. | Summit, N.J. | 07901 |
| Baltimore, MD cernit Pages I and 2 shu Department of Health and Important: If item 27 is nigury or other traumat | | | sposition (Name of cemetery, or other place) | Date 20c. Location - City or | Town, State |
| timent tment ron ot | ш | | een (em. 19 | 72006 H111510 | le, N.J. |
| Balti permit Departr Import injury | | Signature of Funeral Pervice Licence | Name and Address of Facility OSEPH LINEUSS | & Funeral Hom | le Pili |
| Physician | | 23a art I. Enter disease, or complications that aused the death. Do not ent lailure. List driv one cause on each line. | ter the mode of dying, such as cardiac or | respiratory arrest, shock, or heart | Approximate Interval |
| /Medical Examiner | | Implediate Cause (Final disease a. Pulmpnary Thromboembolism | | | Between Onset and Death |
| | | or condition resulting in death) Due to (or as a consequence of): Deep Vendus Thrombosis | | | |
| | her | if any, leading to immediate Due to (or as a consequence of): | | | |
| 11 | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): | | | |
| cuted | | d | | | |
| ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and Chuneral director, page 2 should be detached for use as the burial - transit | Medical | UNPENDED AMENDED | | | |
| 8760, tificate by ng physic as the burn | n/Me | IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth | Fetal death 3 Ectopic pregnal | 23d Date of delivery | y Day Year |
| Box 687 death certifice the attending p | Physician/ | past 12 months? 1 Yes 2 No 9 V Unknown | Other (Specify) | | |
| b. Be the dest by the a | Phy | Part II. Other significant conditions contributing to death but not resulting in t | he underlying cause given in Part I | 23e Did tobacco use contribute to | the cause of death? |
| Division of Vital Records, P.O. tal or attenting Physician: The law requires that the and the death and precedent After this certificate has been signed by led in by the funeral director, page 2 should be detach | l by | | , 5 | 1 Yes 2 No 3 Prob | pably 4 🗸 Unknown |
| rds, requir been s | Completed | | | | topsy findings available ompletion of cause of |
| eco he law ate has age 2 s | dwo | | | performed? death? | |
| ,9 | Be C | 25 Was case referred to medical examiner? | 26.Place of Death (Check of | | |
| F Vit Physic r this c | To E | 1 Ves 2 No Industrial Inpatient 2 VER/Outpat | | g Home 5 Residence 6 Other | |
| n of | | 27 Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time | of Injury 28c. Injury at Work? | 28d. Describe how injury occurred | |
| risio r Atter er deat rector r by th | ficat | 2 Accident Investigation 28e Place of Injury - At home, farm, 5 | 4ccount | 28f. Location (Street and Number or Ru | ral Route Number, City |
| Division of pipel or Attending Phous after death reral Director: After filled in by the funeral | Certification: | Suicide 6 Could not be determined (Specify) | | or Town, State) | |
| Division of Vital To the Hospital or Attending Physician: within 24 hours after datted. To the Fanneral Director: After this certif completely filled in by the funeral director. | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of one) 2 Medical Examiner: On the basis of examination and/or investigation. | | | |
| To th within To th | Medical | one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Mor | |
| | ~ | Ant Canhan | O.C.M.E. | November 27, 20 | |
| n | | 30 Name and address of person who completed cause of death (Item 23a) | | | |
| - J | | Pamela E. Sputhall, MD Assistant Medical Examiner | 111 Penn Street, Baltimore, M | 1D 21201 | |
| S Regis | tate | | West of the second | | |

DHMH 17 Rev 1/2001 OCME 2006

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed. At hours after death.

Funeral Director: After this certificate has been signed by the attending physician and sitely filled in by the funeral director, page 2 should be detached for use as the burial-transi sitely filled in by the funeral director, page 2 should be detached for use as the burial-transi P.O. Box 68760, Records, Division or Vital

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nnent of Health and Mental Hygiene. Instit if item 27 is marked other than "natural", or items 23a or 28a-f show this if item 27 is marked other than "natural", or items 25a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at

Department of Health Important: If item 27 any Injury or other troone.

Physician

/Medical

Saltimore, Maryland 21215-0036

Certification: To

2 Accident 3 Suicide 4 Homicide Medical 29a. Certifier (Check only

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patrier asmodeles

and manner stated.

10755 PAULS 120 SUITE 200 LUTHERWILLE, MD 21093 PATRICIA A. SAVADEL, MD

29c. License number

D27209

29d. Date signed (Month, Day, Year)

11/27/2006

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



DHMH 17 Rev 1/2001

e Funeral

To the within 2.

Please Type or Print in Black Indelible Ink

| August Gamble | 1- For State Registrar | | tate of Maryla | | artment o <i>rtificate o</i> i | | l Mental Hy | | Reg No 200 | 6 3778 |
|---|--|---|---|------------------------|-----------------------------------|---|---|--------------------------|---|--|
| Physician Medical Examine | , August John Gamble, Jr. | | | | | | 2. Date of Death Month Day Year November 26, 2006 | | 3 Time of Death 1208 hrs | |
| j | | 4a. Facility Name (if not institution, give street and number) 10883 York Road # 11 | | | | 4b City, Town, or Location of Death Cockeysville | | | 4c. County of Death Baltimore County | |
| Funeral Director | | 8-4751 | 6 Sex | 7. Age (In yrs 84 | last birthday) Yrs | If Under 1 Year Months Days | If Under 24Hrs. Hours Min. | | rth(MM/DD/YYYY) 9. 8 Fore 24, 1922 | |
| w any | 10a. State | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | | | | 10d Inside City Limits | | |
| death with the Maryland or items 23a or 28a-f show any must be notified at once. | MD 10e Street ar | d Number | imore Co. | Coc | dkeysv. | 1 1:1e | | | log Citizen of What Co | 1 Yes 2 X _{No} |
| with the Nus 23a or penolified | 10883 | York F | | edent Ever in U | S 13. Wa | 2 1 s Decedent of Hisp | 1030 | ecify Yes or No | 0- 14 Race - Ame | rican Indian, Black, |
| hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once red by Funeral Director | > 3 21 VVIGOW | ed 4 Di | Armed Format 1 X Yes vorced If Yes, Give Yea or Dates: | 2 No | If Y | es, specify Cuban, l | Mexican, Puerto | Rican, etc.) | White, etc. Specify: Wh | ite |
| 5-0036 ed within 72 hours tygene other than "natur the Medical Exam | 15. Deceder Elementary | Secondary (0-12) | College (1 | -4 or 5+) | during m | t's Usual Dccupationst of working life. It is the contract of | DD NDT use retir | ork done ed) | Baltimore Board of | Industry County Education |
| 21 be fill mtal h rked emt, | Augus | ame (First, Middle | Gamble,S | | | 18 A | Mother's Name | ary Gi | Maiden Surname) | |
| e, MD 21 I and 2 should Health and Me tiem 27 is ma traumatic ev | Mr. J | ohn Gam | ship (Type, Print) ble(son) | | | Address (Street a | and Number or R | urai Route Nun | nber, City or Town, Statille, MD. 2 | e, Zip Code) 1030 |
| Baltimore, permit. Pages I an Department of Heal Important: If iten injury or other tra | | | n 3 Removal fro | om State | crematory or oth | tion (Name of ceme ner place) Ineral C | ~ <u> </u> | NOV. 39 2006 | | r Town, State Hill, MD. |
| Baltin permit. Departm Importa | | of Funeral Service | | | 22 N | ame and Address o | of Eacility | | | Gremation |
| Physician /Medical Examiner | Tailure. L'I | st only one caus∕e use (Final disease | a Atheroscier | otic Cardiov | ascular Dis | ne mode of dying, su | uch as cardiac or | respiratory arre | est, shock, or heart | Approximate Interval Between Onset and Death |
| _ } | Sequentially li | or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | | | | | | | | |
| ted misit Examiner | Collisease or injury that initiated events resulting in death) Last Due to (or as a consequence of). | | | | | | | | | |
| '60, atte be evecuted bhysician and re burial - trans | UNPENDED AMENDED | | | | | | | | | |
| 6876 certificate anding phy use as the b | IF FEMALE. 23b. Was dece past 12 me | | he 1 Live bi | ant at time of de | 2 Fet | al death 3 er (Specify) | Ectopic pregnan | су | 23d. Date of deliver Month | y Day Year |
| P.O. s that the med by detach | Demen | | tions contributing to | death but not re | esulting in the u | nderlying cause give | en in Part I. | | bacco use contribute to | |
| cords law requi | | | | | | | | 24a. Was a autope perfor | an 24b Were au sy prior to med? death? | utopsy findings available completion of cause of |
| Vital Rechysician: The this certificate all director, page | 25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 | | | | | | f Death (Check or | | Residence 6 ✔ Othe | r Scene |
| ision of Vital I Attending Physician: rdeath. ector: After this certifi by the funeral director, cation: To Be (| 27 Manner of | Death 5 Pend | | of Injury Day:Year) | 28b. Time of Ir | | at Work? 2 | | now injury occurred | |
| <u>``</u> | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| To the Hose completely | 29a. Certifier (Check only 1 one) 2 | ✓ Medical Exa | miner: Dn the basis o and manner st | f examination ar | | | | | e(s) and manner as star and place, and due to th | |
| (Ng) = | 29b. Signature | and title of certifie | er < | | | 29c License r O.C.M. | | | 29d Date signed (Mo. November 27, 20 | |
| 5 | Ana Rub | io MD. Ass | who completed cause sistant Medical E | xaminer | 111 Penn S | reet, Baltimore | e, MD 21201 | | | |
| State Registrar | | NOV 2 | 9 2006 32. | istrar's Signatui | y Apo | W | | | | |

State of Maryland / Department of Health and Mental Hygiene 005 37787 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** November 23, 2006 Hill Givens 05 40 N Juanita /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Hospital Baltimore
If Under 1 Year If Under 24 Hrs. Samaritan last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs Birthplace (State or Foreign Country) Funeral Days 24_ Yrs. 220.18.7876 1 ☐ M 2 🕱 F MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ?? ie marked other than "natural", or Items 23a or 28a-f ehow traumatic event, Ita Medical Examinar must be notified at Baltimore 1 XYes 2 □ No Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21239 1309 Croftor Koad Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Teacher 12th grade byears 18. Mother's Name (First, Middle, Maiden Surname) land 17. Father's Name (First, Middle, Last) Be Carrie Brown Claude David Hill, Sr. ဂ Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 101 6619 Bunie permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau once. Baltimore MD 21209 Drive Juanita Wingo Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Baltimore, MD 30 06 Arbutus Memorial 11 * 4 ☐ Donation 5 ☐ Other (Specify) 27 Nam and Address of Facility Funeral Sowices Yungan Sork Roud Baltimore MD 21212 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Kull HULLYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Onknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy certificate 1 Yes 2 200 the Funeral Director: Alter this certific mpletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 2 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: Natural or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours after Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 7385 November 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boulevanl Raver EVINIT. Serie 560 mos 31. Date filed (Month, Day, Year) 32. State Registrar

ORIGINAL

4926

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 18: 05 Gorman Jerone 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 66 S. Paula Street Laurel Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 MM 2□ F Months Days Hours Min. Director 12/29/1943 Washington, D. Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits must be notified at 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 66 S. Paula Street Funeral 20724 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Electricial Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Tyler Gorman ဥ Marie Cecilia Hayden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other tra once. Maureen Long/ Sister 989 Stormont Circle Halethorpe MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 11-25-2006 Odenton, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non-small /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of) physician Physician/Medical attending p IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death Month Year 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 1□ Yes

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, funeral director. After this within 24 hours after death To the Funeral Director: filled in by

autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) Arsoc Prof. Oncologo License number 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year)

Registrar

harles 31. Date filed (Month, Day, Year) State

MDPLD 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MDPLD

D0061040

Beltman

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend i tem 10e per behar 11729 in Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Phyll.S.L.Garb.S 7:05 AM **Physician** 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Bultimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Maryland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day Year) 02/21/1939 9. Birthplace (State or Foreign **Funeral** 1□M 2**∏**F NY 67 577-50-1530 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2 X No **Funeral Director** BALTIMORE BALTIMORE MD 10e. Street and Number MOR 10g. Citizen of What Country? 10f, Zip Code USA 21208 . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FLORAL DESIGN OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NEMIRO **ZAROFF** FAYE DAVID ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NEW YORK, NY 10033 825 W. 187TH STREET #7-F KERRI GARBIS / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State kING DAVID CEMETERY 11/27/2006 FALLS CHURCH, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician weck neumon /Medical Due to (o' as a consequence of): **Examiner** Custo (uras a consequence of) 4 years Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 ☐ Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 No To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🖸 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)0064160 11-26-06 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Azriel Hirschfeld

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

| Physici | an | 1. Decedent's Name (First, Middle, Las | n | | | | | 2 | . Date of Dea | ath | | | |
|--|------------------|--|---|--------------------------------|--------------------------------------|----------------------|----------------------------------|-----------|--|--|--------------------|--------------------|---|
| /Medic | al | William John Ha | | | 44 63 | _ | | | lovem | oer | 21,20 | | 5:19P |
| Examin | er | 4a. Facility Name (If not institution, give 4801 E. Hoffmar | | | | | Location of Di imore | eatn | | 4C. | | | |
| uneral | | 5. Social Security Number 6. Se | 7. Age (In | yrs. last birthday | If Unde | r 1 Year | If Under 24 I | Irs. 8 | . Date of Birt | h Year | | | (State or Foreig |
| irector | | 213-46-1803 11 Usual Residence of Decedent | 7 M 2□F | 58 Yrs. | Months | Days | Hours N | lin. | June June | 13, | 1948 B | alt: | imore, |
| ehow det | _ | 10a. State 10b. County MD N/ | | a. City, Town or L Baltimo | | | | | | | | | |
| 28a-f | ecto | MD N/ | A | | | p Code | | | | 10a Cit | | | |
| 23a or | Funeral Director | 4806 E. Hoffman | Street | | 101. 24 | | 205 | | United States | | | es | |
| E III | Iner | 11. Marital Status | 12. Was Decedent Ever Armed Forces? | in U.S. 13. | Was Dece | dent of Hi | spanic Origin? n, Mexican, Pi | (Speci | fy Yes or No- | mber 27,2006 5:19PM. 4c. County of Death N/A Birth Pay, Year) 13,1948 Baltimore, Mi 10d. Inside City Limits Country) 13,1948 Baltimore, Mi 10g. Citizen of What Country? United States No- 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Carpentry Ite, Maiden Sumame) Irginia Camp Ther, City or Town, State, Zip Code) Baltimore, MD. 21205 20c. Location - City or Town, State Forest Hill, MD. Cremation Services Reville, MD. 21234 Approximate Interval Between Onset and Death Unknown 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year 24b. Were autopsy findings available prior to completion of cause of death? 27e 2 No 3 Probably 4 Ponknown 23d. Date of delivery Month Day Year 24b. Were autopsy findings available prior to completion of cause of death? 27e 2 No 3 Probably 4 Ponknown 23d. Date of Melivery Month Day Year 24b. Were autopsy findings available prior to completion of cause of death? 27e 2 No 3 Probably 4 Ponknown 25d. Were autopsy findings available prior to completion of cause of death? 27e 2 No 3 Probably 4 Ponknown 25d. Were autopsy findings available prior to completion of cause of death? 27e 2 No 3 Probably 4 Ponknown 27e 2 No 3 Probably 4 Ponknown 27e 2 No 3 Probably 4 Ponknown 27e 2 No 3 Probably 4 Ponknown 28e 2 No 3 Probably 4 Ponknown 29e 20e 20e 20e 20e 20e 20e 20e 20e 20e 20 | | | |
| Coppariment or hearing and when a registral registral and interest, or teme 23s or 28s-f show mortant it tem 27s or 28s-f show eny injury or other treumstic event, the Madical Examinar must be notified at once. | by | 1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | | 1 🗆 Yes | 2 X No | Specify: | | | | | | te |
| n "neti | Completed | 15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) | cation de completed) College (1-4or 5+) | (Give | dent's Usu kind of wo DO NOT u | ork done o | luring most of | working | | 16b. Ki | ind of Busines | ss/Industr | y |
| Trans. | Com | 12 | 01 | | Car | pent | er | | | | | | |
| e veni | To Be (| 17. Father's Name (First, Middle, Last) William John Ha | rtman Sr | | | | | | | | | mn | |
| marke | 2 | 19a. Informant's Name/Relationship (7 | · · · · · · · · · · · · · · · · · · · | 19h Maili | na Address | s (Street a | | | | | | | a) |
| 27 is | | Lisa L. Hartman | | i | | | man S | | | | | | |
| f item | 1 | 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ | Removal from State | Ob. Place of Disponentery, cre | osition (Nai matory or o | me of other place | g) | Dat | | 20c Lc | | • | - |
| tant: I | | 4 ☐ Donation 5 ☐ Other (Specify |) I | Evans F | | | | | 006 | | rest | Hil. | 1, MD. |
| Impor eny in | | 21. Signature of Funeral Service License 22. Name and Address of Facility Evans Funeral Chapel&Cremation Service 8800 Harford Rd. Parkville, MD. 21234 23a. Part Energine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Brinterval | | | | | | | | | | |
| nysician Medical | | Immediate Cause (Final | | death. Do not en | ter the mod | de of dying | such as card | diac or r | espiratory ar | rest. | , | App Inte Ons | roximate rval Between set and Death |
| | | disease or condition resulting in death) | a. Due to (or as a cor | | 130 | | (30) | , (| | | | unkr | nown |
| aminer | | HEPATITIS C | | | | | | | | | | | |
| sit | lner | Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | | | | | | | | |
| n and ial-trar | Examiner | that initiated events resulting in death) Last C | | | | | | | | | | | |
| ysicie ne bur | cal | l | d. | | | | | | | | | | |
| ing ph e as th | Med | IF FEMALE: | | | | | | | | | | i | _ |
| igned by the attending physicien and be detached for use as the burial-transit | by Physician/Med | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown | Fetal death 3 | □Ectopic pi □ Other (sp | | | | | 1 | | | Year |
| gned by be deta | by Ph | Part II. Other significant conditions co | ntributing to death but no | t resulting in the u | inderlying o | cause give | n in Part I. | | 23e. Did to | obacco u | se contribute | to the ca | - |
| peen s | eted | | | | | | | _ | 1 🗆 Y | 'es 2 (| □No 3□ | Probably | 4 Onknow |
| After this certificete hes b funeral director, page 2 s | Completed | | | | | | • | | 24a. Was a autop perfor 1 Yes | sy med?_ | prior to death' | complet | ion of cause of |
| certific rector, | Be | 25. Was case referred to medical examiner? | Hospital: | | | Othe | 26. Place of I | | - | ne) | v Ster | mothe | r's |
| or this | 2 | 1 Yes 2 No 27. Manner of Death | 28a. Date of Injury | 2 ER/Outpatie | | 28c. Injury Work | 4 Nursin | | 5 Describe h | | | ecify) Re | sidence |
| r: Afte | atlo | 1 Matural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Yea | ir) Injury | м | | .? ∕es 2 □ No | | | | | | |
| To the Funerel Director: A completely filled in by the fu | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - building, etc. (Sp | At home, farm, st oecify) | reet, factor | y, office | | 28 | Location (S City or Tow | Street an m, State | d Number or i | Ru <i>ral R</i> ou | ite Number, |
| unere! | edical C | (Crisck Only 2 Medical Exam | sician: To the best of my | knowledge, deat | h occurred | at the tim | e, date and pl | ace, and | d due to the o | ause(s) | and manner | as stated. | causa(s) |
| mplet | Med | one) 29b. Signature and title of certifier | and manner stated. | | | c. License | | | | | e signed (Mo | | |
| 5 5 | |) William Continu | OM, | | 230 | | 2187 | 0 | | NA. | caigned (Mo | Day, | GTL . |
| | | 30. Name and address of person who c | ompleted cause of death | (Item 23a) (Tyne | Print) | | | | | 176 | | MY O | 200 |
| | 7 | oo. Hamo and address of person who c | omproted educe of death | OCH R | | | | | | | | | |

| | | | For State Registrar | State of Marylan | | rtment of H | | | eme 006 | 37791 | | | |
|---------------------|--|----------------|---|--|---|--|--------------------------------|---------------------------------------|--|---|--|--|--|
| | Physici /Medic | | 1. Decedent's Name (First, Middle, Last) | | Ho | BBA | Rn | 2. Date of Death Month | 2 200 | 3. Time of Death (\(\frac{1}{2} \) \(\frac{1}{2} \) \(\frac{1}{2} \) | | | |
| | Examin | | 4a. Facility Name (If not institution, give so Anne Arundel Medi | | | 4b. City, Town, or Annapo | Location of Death 1 is | 1 | 4c. County of Dea | | | | |
| | Funeral Director | | 213 28 7013 | 7. Age (In yrs. 74 | last birthday). Yrs. | Il Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Dec. 5, | 9. Bir 1931 Ma | thplace (State or Foreign ountry) ryland | | | |
| | show | or | Usual Residence of Decedent 10a. State 10b. County Maryland Caroline | | y, Town or Lo | cation | | | | 10d. Inside City Limits | | | |
| | with the N a or 28a-1 | Direct | 10e. Street and Number 11575 Reed Circl | | | 10f. Zip Code 216 | 60 | 10 | g. Citizen of What Co | ountry? | | | |
| 36 | s after death , or itema 23 partner mus | by Funeral | | 2. Was Decedent Ever in U Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates: | 1: | Vas Decedent of H Yes, specify Cuba | ispanic Origin? (S | pecify Yes or No- o Rican, etc.) | 14. Race - Ame Black, Whi | te, etc. | | | |
| Maryland 21215-0036 | within 72 hours after death with the Maryland ene. Then "natural", or Itema 23a or 28a-f show Ite Medical Examinar must be inclibed at | Completed t | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) | ation | (Give | ent's Usual Occup kind of work done OO NOT use retired | during most of wor | rking 1 | 6b. Kind of Business Factor | | | | |
| and 2 | d be filed v ental Hygie ked other t c event, III | Be | 10th 17. Father's Name (First, Middle, Last) Willia | m Hubbard | 1.01.0 | 801 | | ne (First, Middle, M zabeth Tri | a <i>iden Sum</i> ame) | , | | | |
| Mary | nd 2 should th and Mei 27 is mark traumatic | To | 19a. Inlomant's Name/Relationship (Type Joan Hubbard / wi | | 1 | g Address (Street 5 Reed C | | | City or Town, State, Maryland | | | | |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural," or Itema 23a or 28a-f show important: If Item 27 is marked other than "natural," or Itema 23a or 28a-f show injury or other traumatic event, Ite Medical Examinat must be rediffed at ance. | | 20a. Method of Disposition Date | | | | | | | | | | |
| B | permi Depa Impo eny ii | | 23a. Part1. Enter the disease, or compile shock, or heart lailure. List only on | more, Mar | yland 21225 Approximate Interval Between Onset and Death | | | | | | | | |
| 13 | Physician /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) | Due to (or as a consec | - 1 - 1 | 10 00 | (Na | CANCE | , , | MONIT | | | |
| 8760, | cate be executed physicien and the burial-transit | dical Examiner | Sequentially flet conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consecutive to (or a consecutive to (or a consecutive to (or as a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a co | | | | | 23d. Date of delivery Month Day Year | | | | |
| .O. Box 6 | The law requires that the death certifical ten has been signed by the attending phyage 2 should be detached for use as the | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of o 9 □ Unknown | al death 3 | Ectopic pregnancy Other (specify) | , | | | | | | |
| ۵. | quires that n signed b uld be deta | b | Part II. Other significant conditions con | tributing to death but not res | sulting in the u | nderlying cause giv | ren in Part I. | | | o the cause of death? | | | |
| al Records, | (0) | Completed | | | | | | 24a. Was an autopsy perform | ed? prior to death? | utopsy lindings available completion of cause of | | | |
| of Vital | yaic is ce direc | To Be | 1 Yes 2 No | | ER/Outpatier | | ier: 4 🗆 Nursing F | | nce 6 Other (Spe | ecify) | | | |
| Division o | tending leath tor: After the fune | Certification: | 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | M 1 🗆 | yat k? Yes 2 □ No | 28d. Describe how | eet and Number or F | iural Route Number, | | | |
| Div | i Sign | | 4 Homicide determined 29a. Certifier 110 Certifying Phys | building, etc. (Speci | ify) owledge, deatl | occurred at the ta | me, date and place | City or Town, | use(s) and manner a | s stated. | | | |
| | To the Hospital within 24 hours a To the Funeral I completely filled | Medical | (Check only 2 Medical Examination) 29b. Signature and title of certifier | ner: On the basis of examinating and manner stated. | ation and/or in | 29c. Licens | e number | arred at the time, da | te and place, and du d. Date signed (Mon | e to the cause(s) | | | |
| | 4 | | 30. Name and address of person who co | mis and cause of death (Ite | m 23a) (Type. | ey D | 2143 | 14 | NOVZ | 6 2806 ANNAPOUSIN | | | |
| | () | ate | MICMR J. C. 31. Date filed (Month, Day, Year) | ACVIA was 32. Raistrar's Sign | YL | 1 100 | TENSE | 1167 | HWAY | TONAFOLISM | | | |
| 150 | Regist | | | and Marcus | B. 4 | DENCE! | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

| Physici /Medic Examin | al |
|-----------------------------|----|
| Funeral Director | |

it. Pages 1 and 2 should be filed within 72 hours after death with the Marylan surnent of Health and Mentat Hygiene.
Intent: if itam 27 le marked other then "naturel", or items 23a or 28a-1 show njury or other traumatic event, the Macifical Execution mast be notified at permit.
Departn
Importe
any inju

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, physicien the attending p for use as signed b : certificate within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Heim Edward 13:30 M James 11 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore City Baltimore VA Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 10M 20 F New York 098-38-9349 58 6/1947 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Buffalo NY Erie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 566 Lisbon Avenue 14215 United States Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Xyes 2 □ No 1968 −
If Yes, Give
Year or Dates: 1978 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plant Manager Chemicals 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marion P. Buchauer Herbert G. Heim ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 566 Lisbon Avenue, Buffalo, NY 14215 Nancy Heim - Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Bath National arcther place) Burial 2 □ Cremation 3 □ Removal from State Donation 5 Other (Specify) Cemetery 11
22. Name and Address of Facility 11-27-2006 Bath, New York 21. Sona ure of Fundral S Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 Part1. Enter the disease, or complications that clused the shock, or heart failure. List only one cause on each line. sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Multi-system organ failure Due to (or as a consequence of): Biliary sepsis Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or all a consequence of): Examine olon cancer metastatic with si net rin cells Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus type II 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Hepatitis history of 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier surgical resident 2006 AU4176435F 17560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 124 N Belnord Ave Max Fischer Baltimore, MD 21224 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 2 9 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2:00 a_M Physician Conner Phillip Hopf 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard 7746 Rockburn Drive Ellicott City 8. Date of Birth
Jan. 25, 2005 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1**25**M 2□F Mary land 217-71-6912 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 ehroring injury or other traumatic event, the Medical Euroric 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Ellicott City Howard MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21043 United States 7746 Rockburn Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: White 1 □ Yes 2X No ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Desiree Marie Allin Carl George Hopf ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7746 Rockburn Dr., Ellicott City, MD 21043 Carl G. Hopf - Father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Transfery, Armatory of their place)
We Crematory 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 11-28-2006 | Odenton, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ambrosc Funeral Home, Inc. 21. Sign thre of Funer I rvice Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of 90 Manh **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No Д Д 24a. Was an autopsy 2 No N/A 2X No 1□ Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2Â No 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29c. License number D 00 2 3 4-15 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COLUMBIA 100

PKWZY COLUM

| | | | 1 - For State Registrar | State of Marylar | nd / Depa <i>Cer</i> | rtment of H | lealth and <i>Death</i> | Mental Hy | giene 0 0 | 37794 | |
|------------|--|------------------|---|---|-------------------------------------|---|--------------------------------------|---------------------------------------|---|--|--|
| | Physici | an | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of De | aath Day Year | 3. Time of Death | |
| | /Medic | | Maudie Bell Howell | | | | | NOV | 21 200 | | |
| ,to | Examir | ner | 4a. Facility Name (If not institution, give s ST · AGN∈S +1 | | , | 4b. City, Town, or | Location of Dea | | 4c. County of Death | | |
| | . | | 5. Social Security Number 6. Sex | | | If Under 1 Year | | | th Q.R | inthplace (State or Foreign | |
| Н | Funeral Director | | | ^{1M 2} | Yrs. | Months Days | Hours Mir |). (Month, Da | 7, 1930 Kej | Country) | |
| | p , | | Usual Residence of Decedent | 10.0 | | | | Journe 2 | 7, 1750 Rej | | |
| | ehov | 2 | 10a. State 10b. County | | ity, Town or Lo | cation | | | | 10d. fnside City Limits 1 ☐ Yes 2 ☑ No | |
| | 28a-f | Funeral Director | MD Baltimore | Lan: | sdowne | 10f. Zip Code | | | 40-000-000 | | |
| | With With | 2 | 160 Howard Avenue | | | 21227 | | | 10g. Citizen of What (| country? | |
| | ms 2: | nera | | 12. Was Decedent Ever in U | J.S. 13. V | Vas Decedent of Hi Yes, specify Cuba | ispanic Origin? (| Specify Yes or No | U.S.A. 14. Race - Arr | | |
| တ္က | or Its | Fui | 1 ☐ Never Married 2 ☑ Married | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give | | | | rto Rican, etc.) | | | |
| 8 | be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel", or Items 23e or 28e-f ehow event, I're Madical Eracificat must be notified at | d by | 3 ☐ Widowed 4 ☐ Divorced | Year or Dates: | | ☐ Yes 2 No | Specify: | | Specify: W | hite | |
| 21215-0036 | n 72 l | Completed | 15. Decedent's Educ (Specify only highest grade | | (Give | ent's Usual Occupa kind of work done o OO NOT use retired | during most of we | orking | 16b. Kind of Busines | s/Industry | |
| 212 | withi | mo | Elementary/Secondary (0-12) | Coflege (1-4or 5+) | | y Worker | , | | General E | lectric | |
| פַ | e filec al Hyg othe vent, | Bec | 17. Father's Name (First, Middle, Last) | | TACLUL | y WOLKEL | 18. Mother's Na | ame (First, Middle | , Maiden Sumame) | | |
| <u>a</u> | should be filed within 72 hours after death with the Marylan nd Mental thygiene. In marked other than "naturel", or Items 23s or 28s-1 show matic event, Its Madical Exactinational be notified at | ToE | Grant Miracle | | | | Cordia | Bell Hos | kine | | |
| Maryland | s 1 and 2 should f Health and Mer Item 27 is marke other traumatic | | 19a. Informant's Name/Relationship (Typ | • | | | | | er, City or Town, State, | Zip Code) | |
| | 1 and Health In 27 | | Lawrence Howell/ H | 005 | Dia Di | oward Ave | | - | | | |
| Baltimore, | ages nt of th | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re | emoval from State Me | adowric | atory of other place | al 11_ | 27-2006 | Elkridge, | Moseral and | |
| | artme crtent njury | | 4 Donation 5 Other (Specify) 21. Sign ture of Funeral Service, List se | | 22 | Name and Address | s of Facility | | | Maryland | |
| e H | permit. Pages 1 a Department of He Importent: If Iten any injury or oth | | Mariollo | Kanakier | 1 Am | orose fur | ieral Ho | me Lansd | owne | 0.4.0.0 | |
| | | | 23a. Part1. Enter the disease, or complic | cations that caused the dea | th. Do not ente | r the mode of dying | IGS_Perr g, such as cardia | y KO. La ac or respiratory a | nsdowne MD | Approximate | |
| ţ. | Physician | | shock, or heart failure. List only on fimmediate Cause (Final disease or condition | e cause on each line. | Aen, | RATION | PNIG | HONIO | | Onset and Death | |
| | /Medical | | resulting in death) | Due to (or as a consec | | KUITON | Trice | HONIE | | 9 DAYS. | |
| | Examiner | | Sequentially list conditions. | | CHEMI | c CAI | RDIOM | HOPATH | 4 | A YEARS | |
| | 2 /b/ 5 | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consec | quence of): | | | | | | |
| | and al-tran | хап | that initiated events resulting in death) Last | Due to (or as a consec | luence of): | | | | | | |
| 8/60 | ficate be executed physicien and Es | dlcal E | L. | , | | | | | | | |
| ğ | ifficate g phy as the | edk | 0. | | | | | | | | |
| ŏ | w requires that the death certific been signed by the attending p should be detached for use as | Physician/Me | 23b. Was decedent pregnant | 3c. If yes, outcome of pregnature 1 ☐ Live birth 2 ☐ Feta | | Ectopic pregnancy | | | 23d. Date of de | elivery | |
| | e deal | sicis | in the past 12 months? 1 Yes 2 No | 4☐Pregnant at time of o | | Other (specify) | | | Month | Day Year | |
| 7. O | hat the | | 9 Unknown | | ltine in the | 4 . h | - In Board | an Dit | | | |
| Kecords, | signe d be c | 1 by | Part II. Other significant conditions conf | | | ACC (DE) | | | obacco use contribute t res 2 □ No 3 □ P | robably 4 🖫 vinknown | |
| Ö | v requ | Completed | CRES | NO VIISCO | CTIO | 11 | 1517 | | | . 7 | |
| ě | a sc | mp | | | | | | 24a. Was autop perfo | an 24b. Were a prior to death? | utopsy findings available completion of cause of | |
| _ | | ပိ | 25. Was case referred to medical | | | | 00 Di/ D- | 1 ☐ Yes | 2 XNo 1 □ Ye | s 200/No | |
| = | Physician: this certific ral director, | 0 8 | | ospital: 1 / Inpatient 2 🗆 | ER/Outpatient | 3□ DOA Othe | | ath <i>Check</i> only o | dence 6 □Other (Spe | acifu) | |
| 0 | ng Phys ter this neral dii | Ju: T | 27. Manner of Death | 28a. Date of fnjury (Month, Day Year) | 28b. Time of Injury | 28c. Injury Work | | | now injury occurred | scriy) | |
| <u> </u> | endir eath. or: Af | atlc | 2 ☐ Accident investigation | (,, ,, | ,, | | es 2 □No | | | | |
| Division | al or Att after d Direct d in by t | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of fnjury - At h building, etc. (Specif | ome, farm, stre | et, factory, office | | 28f. Location (S City or Tox | Street and Number or R vn, State) | ural Route Number, | |
| | To the Hospital or Attending Ph within 24 hours atten death. To the Euneral Director: After th completely filled in by the funeral | Medical (| 29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examin | ician: To the best of my kno er: On the basis of examina and manner stated. | owledge, death ition and/or invi | occurred at the time estigation, in my op | e, date and plac inion, death occ | e, and due to the ourred at the time, | cause(s) and manner a date and place, and du | s stated. e to the cause(s) | |
| | To the To the | Me | 29b. Signature and title of certifier | | | 29c. License | | | 29d. Date signed (Mon | | |
|) | | | Suvaechi | ile. | | PI | 992 | 3. | Nov 3 | 1 2006 | |
| | | | 30. Name and address of person who cor | npleted cause of death (Iten | n 23a) (Type, F | rint) | | | | | |
| | 4 | | SUVARCHALA K | | MD | 31.1 | + GNIES | HOSPITA | +L, BALTI | MORE, MD | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 2. 9 2006 | 2. Registrar's Signa | elure dose | 200 | | | | | |

DHMH 17 Rev 1/2001

HOWELL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 27,2006 **Physician** November 2:10 p M Grace Hauck /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Pickersgill Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 8,1905 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 □ F New York 101 212-52-6661 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2212 Boxmere Road 21093 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ģ 3 X Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ene. than " Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important: If item 27 is marked other i any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Battenfeld Kyle Ernest J. Agnes ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Ann Foell / Daughter 2212 Boxmere Road Timonium, Mď. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Cem. 12/1/06 Timonium, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service I cense 1050 York Road a Ruck Towson Funeral Home, Inc. Towson.Md.21204 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complete shock, or heart failure. List only the ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on the control of t Immediate Cause (Final Physician RAR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After this filled in by the funeral 27. Manner of Death 1 Matural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) November 27, 2006 30. Name and address of person who completed cause of deal (Item 23a) (Type, Print) V. Charles St. Beelto ind 21205 Bune 2. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 2 9 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical (If not institution, give street and number) Town, or Location of Death 4c. County of Death 4a. Facility Examiner AUENL Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 2 🗆 F 1 XM Director Jashington, D.C with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director ΔN timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ewelyn Avenu permit, Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a any injury or other traumatic event, the Medical Function of Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify. Specify: Black þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ohnson 1to.MD 21212 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore, MI 21. Signature of Funeral Service Licensee Services oad Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Uremia month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner rostate cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Du to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy tate has been signed by the atterpage 2 should be detached for a in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hupertension 1 Tyes 2 00 3 ☐ Probably 4 ☐ Unknown Completed cerebrousenlar dizease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy perform certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation s after dea. 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 ☐ Homicide Hospital 24 hours a within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 52008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grea o N. Caroline St. Baltimune MD 36 31. Date filed (Month, Day, 32 gistrar's Signatur State NOV 29 2006 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death **Physician** Jorda. Kokidia 11 06 7 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 212 F 218-86-475 Usuel Residence of Decedent Yrs. 30 Director Pages 1 end 2 should be filed within 72 hours efter death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 TNes 2 □ No **Funeral Director** 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 3051 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1□ Yes 25 No Baltimore, Maryland 21215-0020 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. condary (0-12) College (1-4or 5+) ntanance 1echanic d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Be Department of Health and Mental Important: If Item 27 is marked or any injury or other traumatic eve Margie ဥ Marvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) +Jorda Balto MD Method of Disposition

↑ Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical GLSTI'C Carce Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requiras that the death certificate be executed use as the bunel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. that initieted events Due to (or as e consequence of): resulting in death) Lest cata has been signed by the e page 2 should be datached to 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown edical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1∐Yac 2⊞% 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Mann of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigetion To the Hospital or Attendi within 24 hours aftar death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60812 11/22/06 Baltimore, MD Z1287 a tdr ss of person who completed cause of deeth (Item 23a) (Type, Print) N. Wolfe Street Phipps 281 31. Date filed (Month, Day, Year) NOV 2 32. gistrar's Signature State 2006 Registrar

06-08869 Scott A. Jones

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hy

| | | | epartment of Health and Certificate of Death | | eg. No. 2006 3779 | | | | | |
|---|----------------|--|--|--|--|--|--|--|--|--|
| Physic | | | | 2. Date of Dea | th 3 Time of Death | | | | | |
| fledical Exam | inei | Scott Alan Jones, —Sr. 4a. Facility Name (if not institution, give street and number) | | Novembe | r 21, 2006 1103 hrs | | | | | |
| | | Bon Secours Hospital | 4b. City, Town, or L Baltimore | ocation of Death | 4c. County of Death | | | | | |
| Funeral | | | rs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Bir | th(MM/DD/YYYY) 9. Birthplace (State or | | | | | |
| Director | | | 35 Yrs. Months Days | Hours Min. June | Foreign | | | | | |
| | | Usual Residence of Decedent | | | | | | | | |
| w an | | | City, Town or Location | | 10d Inside City Limits | | | | | |
| Aaryland 28a-f show any 1 at once, | ģ | MD N/A 10e. Street and Number | Baltimore | | 1 X Yes 2 No | | | | | |
| th the Maryland 23a or 28a-f sho notified at once | I Director | | 10f. Zip Code 21223 | | 0g. Citizen of What Country? USA | | | | | |
| Baltimore, MD 21215-0036 permit Pages I and 3 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens (Health and Mental Hygiens), or items 23a or 28a-f sho important: If item 27 is marked other than "natural", or items 23a or 28a-f sho july ryne, ther traumatic event, the Medical Examiner must be notified at once | Funeral | 11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X New York Name of the Armed Forces | o If Yes, specify Cuban, | anic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.) | - 14. Race - American Indian, Black, White, etc. | | | | | |
| rs afte ıral", | by | 3 Widowed 4 Divorced If Yes, Give Year or Dates: | 1 Yes 2 No | | Specify: White | | | | | |
| 2 hour | ted | Elementary/Secondary (0-12) College (1-4 or 5+) | 16a. Decedent's Usual Occupation during most of working life. [| on (Give kind of work done DO NOT use retired) | 16b. Kind of Business/Industry | | | | | |
| 5-0036 led within 72 hours a Hygiene. other than "natura the Medical Examig | Completed | 10 | HVAC Tech | | Heating and Air | | | | | |
| 15-(filed v I Hygi ed oth | | | 18 | 3. Mother's Name (First, Middle, N | , | | | | | |
| 2121 Jid be fill Mental H marked | o Be | | 19h Mailing Address (Street | Nancy Y. Phar | es ber, City or Town, State, Zip Code) | | | | | |
| s, MD 2121 and 2 should be fi fealth and Mental tem 27 is marked traumatic event, | | Cynthia Haslup, sister | 2566 Wilkens | | | | | | | |
| e, E, I and I and Healt Fitem | | 20a. Method of Disposition 20 | b. Place of Disposition (Name of ceme crematory or other place) | | 20c. Location - City or Town, State | | | | | |
| Baltimore, permit. Pages I ar Department of Hee Important: If ite | | 1 X Burial 2 Cremation 3 Removal from State 4 Departion 5 Other Specify | ew Cathedral Ceme | tory 11_28_06 | Poltimore Mp | | | | | |
| Salti rmit. spartm sports | , | 1. Signature of Funding Service Liberase | 22. Name and Address o | f Facility | The state of the s | | | | | |
| | (| Allena Mary La | 2719 Hammo | neral Home of i | Lansdowne MD 21227 | | | | | |
| Physician /Medical | | | | | | | | | | |
| Examiner | Death | | | | | | | | | |
| 1 | | or condition resulting in death) Due to (or as a consequence b. | e 01). | | | | | | | |
| | iner | if any, leading to immediate Due to (or as a consequence cause Enter Universitying Cause | e of): | | | | | | | |
| | Examiner | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence | e of): | _ | | | | | | |
| 68760, certificate be executed nding physician and se as the burial - transi | | d. | | | | | | | | |
| 760, cate be execut physician and he burial - tra | Medical | MUNPENDED AMENDED #1,23a,2 | 27,28a-f, perme, G863, | 1/2/07 TT | | | | | | |
| 8760, ifficate by up physical streets but | - | IF FEMALE: 23c. If yes, outcome of pr | egnancy | | 23d. Date of delivery | | | | | |
| Vital Records, P.O. Box 68: hysician: The law requires that the death certifi this certificate has been signed by the attending I director, page 2 should be detached for use as it. | Physician | past 12 months? 4 Pregnant at time of | | Ectopic pregnancy | Month Day Year | | | | | |
| Box he death c the atten hed for us | hys | 1 Yes 2 No 9 Unknown 9 Unknown | | | | | | | | |
| P.O. | by F | Part II. Other significant conditions contributing to death but no | t resulting in the underlying cause give | | pacco use contribute to the cause of death? | | | | | |
| dS, equires | Completed | | | 1 Yes | | | | | | |
| COT law ri has b | nple | | | autops | y prior to completion of cause of | | | | | |
| Re: The | | OF Was and of such as a su | | 1 Y Yes 2 | | | | | | |
| /ital | o Be | 25 Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 | | Death (Check only one) her4 Nursing Home 5 F | No. | | | | | |
| Division of Vital Records, at or Attending Physician: The law requirers after death at Director: After this certificate has been sited in by the funeral director, page 2 should be | - | 1 V Yes 2 No 1 V Inpatient 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury 28c. Injury a | | Residence 6 Other: | | | | | |
| on endin sath or: A | ij | Pending F. 1 11 /21 /200 | Yes 1 To Yes | 3 2 V No . | | | | | | |
| ivision or Attenc after death Director: | ifica | 2 Accident Investigation PTG 11/21/20. 3 Suicide 6 X Could not be 28e. Place of Injury - At | home, farm, street, factory, office build | ding, etc. 28f. Location (St | reet and Number or Rural Route Number, City | | | | | |
| spital lours a filled | Certification: | 4 Homicide determined (Specify) other-s | scene | or Town, Sta Baltimor | | | | | | |
| Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this sentil completely filled in by the funeral director, | | 29a Certifier (Check only one) 2 Medical Examiner: On the best of my knowle | edge, death occurred at the time, date | and place, and due to the cause | (s) and manner as started. | | | | | |
| To t with Com | Medical | and manner stated 29b. Signature and title of certifier | 29c. License n | | | | | | | |
| | | Tol NAC | O.C.M. | | 29d. Date signed (Month, Day, Year) | | | | | |
| (4/1 | | 30. Name and address of person who completed cause of death (Ite | | | November 22, 2006 | | | | | |
| U | | Zabiullah Ali, M.D. Assistant Medical Examine | , | ore, MD 21201 | | | | | | |
| St Regist | | 1 1011 0 0 100C 164- 4- | ature (| - | | | | | | |
| regist | الند | 70000 | 7 | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 8861 11-29-06 vt. State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Willie November 25 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital N/A Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Septith, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Mary land Days Months Hours 1 X M 2 □ F 220-80-1672 incher 21, 1960 Director Usual Residence of Decedent so 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f show then 72 marked the promise oven, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore 1 X Yes 2 □ No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 South Herring Court United States 21231 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Laborer 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bernice Thomas Willie Kinard ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum once. 1723 Lamont Avenue Baltimore, Maryland 21202 Darlene Tiller-20b. Place of Disposition (Name of cemetery, crematory or other place) November 30 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Balto, MO Mount Carnel Com 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature Funeral Service Licensee 22 Name and Address of Facility Calvin L. Williams Funeral Service, P.A. P.O. Box 11451 Baltimore, Maryland arvin d. Baltimore, Maryland 21229 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Neumoni Physician Nee /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner physician and s the burial-transit that initiated events resulting in death) Last that the death certificate be execu Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ed by the a P.O. 9 Unknown this certificate has been signed la director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death, To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title prefile AT 2438946 November /25/2006 Memorial Hospital, MD f person who completed cause of death (Item 23a) (Type, Print) Bashar - ar Registrar's Signature 31. Date filed (Month, Day, Year) State 29 NOV 2006 Registrar

37800

| Frobles, Lova Beltimore Meruland 21215-0036 | permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Itema 23a or 28a-f ehow any injury or other traumatic event, the Moulcal Examinat must be notified at once. |
|---|--|
|---|--|

Physician /Medical Examiner For State Registrar

Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit # 34/4 Division of Vital Records, P.O. Box 68760,

| | | Decedent's Name (First, Middle, Last) | | | 2. Date of Dea | | | 3. Time of Death |
|--|--------------|--|----------------------|--|--|--------------|----------------------------------|---------------------------------------|
| Physici Medio/ | | LORA | | KNOBLER | NOVEMBE | ₹ 17 | 2006 | 5:30A M |
| Examir | | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or Location of D | | _ | ounty of Death | 0.000 |
| | | LEVINDALE HEBREW HOME | | BALTIMORE | | | | N/A |
| uneral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last bit | rthday) | If Under 1 Year If Under 24 | | Vear | 9. Birthp | lace (State or Foreign |
| irector | | 219-70-1227 1 1 N 2 X F 78 88 | Yrs. | Months Days Hours | 12/04/19 | 27 | ROMA | ΝΊΑ |
| > 000 | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow | | | | | | |
| eho iii | 2 | | | MORE | | | 1 | 0d. Inside City Limits 1 X Yes 2 □ No |
| 28a-f | Director | | | | | | | |
| E or | | 10e. Street and Number 4201 FALLSTAFF ROAD | | 10f. Zip Code | 1 | _ | n of What Coun | try? |
| a 23 | rai | | 10.11 | 21215 | | | .S.A. | |
| ltem F | Funeral | 11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 11. Yes 2 M No | 13. V | vas Decedent of Hispanic Origin' Yes, specify Cuban, Mexican, P | (Specify Yes or No- uerto Rican, etc.) | 14. | . Race - Americ Black, White, | |
| 0.1 | by | 3 ☑ Widowed 4 □ Divorced Year or Dates: | 1 | Yes 2 No Specify: | | Sp | pecify: | |
| atura Esta | | 15. Decedent's Education 16a | | ent's Usual Occupation | | 16b. Kind | of Business/Inc | HITE Justov |
| N N | ple | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | (Give l | kind of work done during most of O NOT use retired) | working | | | , |
| - 4 | Completed | | NER | | | GR | OCERY | |
| 1 oth | Be (| 17. Father's Name (First, Middle, Last) Kend] | | | Name (First, Middle, I | Maiden Su | imame) | |
| arke | ြို | YANKU KNOBL | ER | SUSEE | | U | NKNOWN | |
| is m | 2 | 19a. Informant's Name/Relationship (Type, Print) | . Mailing | g Address (Street and Number of | r Rural Route Number | City or T | own, State, Zip | Code) |
| m 27 Ter tr | 1 | SAM KNOBLER / SON | | GREENWICH PLACE | | RE, | MD 2120 | 8 |
| or off | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of cemeter | f Dispos ry, crem | ition (Name of atory or other place) | Date | 20c. Loca | tion - City or To | wn, State |
| tant: jury | | 4 Donation 5 Other (Specify) ADATH | ISR | AEL 11/ | 19/2006 | BALT | IMORE, | MD |
| Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once. | | 21. Signature of Funeral Service Licensee | 22. | Name and Address of Facility S | OL LEVINSO | N & 1 | BROS | INC. |
| = # O | | Molet Chom | 890 | OO REISTERSTOWN | ROAD - PI | KESV | ILLE, M | D 21208 |
| | | 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. | | | | st, | | Approximate Interval Between |
| sician | | Immediate Cause (Final disease or condition | er' | 1 Disease | 1 | | | Onset and Death |
| edical iminer | | resulting in death) Due to (or as a consequence | | | | | (| |
| | _ | Sequentially list conditions, b | 1900 | | | | | |
| sit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | | | |
| and I-tran | хап | that initiated events resulting in death) Last C. Due to (or as a consequence | of): | | | | | |
| icien | | 233 (8) (8) 23 2 32 (8) | 0,,. | | | | | |
| attending physicien and for use as the buriel-transit | clan/Medical | d. | | | | | | |
| ding ise a | /We | IF FEMALE: 23c. If yes, outcome of pregnancy | | | | 004 | D-11(-1-0 | 4 |
| | clar | in the past 12 months? | | Ectopic pregnancy Other (specify) | | 230 | . Date of deliver Month | y Day Year |
| y the | Physi | 9 □ Unknown 9 □ Unknown | Ū | Outer (specify) | | | | |
| To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached | y PI | Part II. Other significant conditions contributing to death put not resulting in | n the un | derlying cause given in Part I. | 23e. Did tob | acco use | contribute to the | a cause of death? |
| n sign | ed by | Mitral Valve Prolapse | 2 | | 1 □ Ye | s 2 | 3 Proba | ably 4 Unknown |
| shor | Completed | arteophanis | | | 24a. Was ar | 2 | Ah Wara auton | sy findings available |
| e has | mc | 0375070313 | | - | autopsy perform | , | prior to com death? | pletion of cause of |
| or. pi | Ö | 25. Was case referred to medical | | - 00 Place - 44 | The same of the sa | X (4) | 1 🗆 Yes | 2□ No |
| s cert | OB | examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Ou | itnatient | 04 | Death (Check only one | | 304 | |
| eral o | on: T | 27. Manger of Death 28a. Date of Injury 28b. | Time of | 28c. Injury at Work? | g Home 5 Reside | | | / |
| e fun | atlo | 1 Matural 5 ☐ Pending (Month, Day Year) ! 2 ☐ Accident investigation | njury | Work? M 1 Yes 2 No | | | | |
| ecto by th | ific | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify) | ırm, stre | et, factory, office | 28f. Location (Str | eet and N | lumber or Aural | Route Number, |
| ni De | Certificat | building, etc. (<i>Specily</i>) | | | City or Town | State) | | |
| In fill | | 29a. Certifier (Check only Medical Examiner: On the basis of examination and | , death | occurred at the time, date and pla | ace, and due to the ca | use(s) and | d manner as sta | ited. |
| he Fi | edical | (Check only one) Medical Examiner: On the basis of examination an and manney stated. | d/or inve | astigation, in my opinion, death of | | | | |
| Com | Σ | 29b. Signature and tyle of certifier | | 29c. License number | 29 | d. Date si | igned (Month, D | 11/17/06 |
| | | 1XV/1/ /m | | 13394 | 5 7 | 1//0 | 0/06 | 11/1//00 |
| | | 30. Name and address of person who completed cause of death (Item 23a) | (Туре, Р | rint) / /a | | 1 | - | |
| | | Jusan VII Levy L | Cul | nace | / | | | |
| Sta | _ | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | | | | | |
| Registra | ar | NOV 2 9 2006 Status NOV 2 9 2006 | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 37801 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 11:40 A.M Francis Joseph Kostek, Jr. November 23 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Sykesville Continuum Care 8. Date of Birth (Month, Day, Year) May 15, 1915 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours 93 Maryland Director 213 10 3487 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28e-f show 10c. City. Town or Location 10d Inside City Limits 10a State 10h County itam 27 is marked other than "natural", or items 23a or 28e-1 show other traumatic evant, the Madical Examinar must be notified at Maryland 1 Yes 2 No Carrol1 Mt. Airv Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 3801 Mt. Airy Drive 21771 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ☐Yes 2 No Yes, Give 1 ☐ Never Married 21 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician Food Machinery 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Vicen Frank Joseph Kostek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene E. Kostek / Wife 3801 Mt. Airy Drive Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō permit. Page Department of Important: If any injury or once. Glen Haven Mem. Park 11/28/2006 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheima Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai Examiner burial-transit The taw requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy 1 ☐ Yes 2 No To the Hospital or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 💢 No 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1XX Natural I Diractor: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Momicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 51705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster mp 21157 M. PANSURIYA resolvolm 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

| | | | 1 - For State Registrar | State of Maryla | • | | t of Hea | | Mental Hy | /gien | 2000 | 37802 | |
|---|--|---------------------|---|--|------------------------------|-------------------------|------------------------------------|---|------------------------------------|--|---------------------------|---|--|
| | Physici /Medic | cal | Decedent's Name (First, Middle, Last) Helen Louise Ke 4a. Facility Name (If not institution, give s | rn | | 4b. City, | Town, or Loc | cation of Death | 2. Date of D Month Novemb | per 2 | Year 25, 2006 | 3. Time of Death 6:30 P. M | |
| :6:30pm | Funeral Director | | 3710 St. Johns La 5. Social Security Number 6. Sex 220-18-4163 Usual Residence of Decedent | 7. Age (In yr | s. last birthday, 30 Yrs. | | 1 Year If | tt City Under 24 Hrs. Jours Min. | 8. Date of B (Month, D March | ay, Year, | Howard 9 Birth Co 926 Mar | nplace (State or Foreign untry) yland | |
| HR | death with the Maryland ms 23a or 28s-1 ehow rmust be notified at | ector | 10a. State 10b. County Maryland Howard 10e. Street and Number | 10c. (| City, Town or L | | | | | 10d. Inside City Limi 1 ☐ Yes 2 ☑ N | | | |
| 11/25/06 | r death with tems 23e or er must be r | by Funeral Director | 3710 St. Johns La | 12. Was Decedent Ever in Armed Forces? | U.S. 13. | | 21042 | nic Origin? (Sp | pecify Yes or No Rican, etc.) | USA | | | |
| 111 000 | 5-0036 72 hours afte natural; or If | eted by Fu | 1 ☐ Never Married 2 ፟ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ (Specify only highest grade | 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | 16a. Dece | 1 ☐ Yes | 2 ☑ No S | pecify: | | | ite | | |
| 30 | nd 2121 a filed within il Hygiene. other then " | Be Completed | Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last) | Homemaker | | | aker | ing most of working B. Mother's Name (First, Middle, I | | | Own Home Maiden Sumame) | | |
| L. KERN | Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: It florm 27 is marked other then "natural", or Items 23e or 28e-1 ehov any injury or other traumatic event, the Medical Examiner must be notified at once. | To B | Richard G. Rebbert 19a. Informant's Name/Relationship (Ty) Robert R. Kern, Sr | oe, Print) | | - | | Number or Rui | | ber, City | or Town, State, Z | Tip Code) Yland 21042 | |
| 1 | Baltimore, I berarii: Pages 1 and Department of Heali Importent: If Item 2 Inty injury or other once. | | 20a. Method of Disposition 1 \(\begin{align*} \text{1 Disposition} \) 1 \(\begin{align*} \text{2 Dermation} & 3 \text{Removal from State} \) 4 \text{Donation} & 5 \text{Other (Specify)} \) 1 \(\begin{align*} \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 1 \(\begin{align*} \text{New Cathedral Cemetery} \) 11 \(\begin{align*} \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 12 \(\begin{align*} \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 13 \(\begin{align*} \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 14 \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 15 \(\begin{align*} \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 16 \(\begin{align*} \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 17 \(\begin{align*} \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 18 \(\begin{align*} \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 19 \(\begin{align*} \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 10 \(\begin{align*} \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 10 \(\begin{align*} \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 11 \(\begin{align*} \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 12 \(\begin{align*} \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 13 \(\begin{align*} \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 14 \(\begin{align*} \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 15 \(\begin{align*} \text{20b. Place of Disposition (Name of cemetery, crematory or other place)} \) 16 \(\begin{align*} 20b. Place of | | | | | | | 20c. Location - City or Town, State | | | |
| HELEN | Balt permit. Depart Import | | 21. Signature of Funeral Service license 23a. Part1. Enter the disease, or complishock, or heart failure. Aist only on | 05 | | Fune 1630 | eral H O Edmo | ome of ndson A | Catons venue; | villo Cato | e, Inc. | MD 21228 Approximate Interval Between | |
| | served. Itale be executed Wedical Examiner Physician and physician and s the burial-transit | edical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if arry, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | |
| | Division of Vital Records, P.O. Box 68 for attending Physician: The law requires that the death certifica after death. After this certificate has been signed by the ettending phin in by the funeral director, page 2 should be detached for use as the contract of the contr | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown | 3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown | tel death 3 | ath 3 Ectopic pregnancy | | | | | | | |
| | cords, P | <u>م</u> | Part II. Other significant conditions con | tributing to death but not re | esulting in the u | underlying c | ause given in | Part I. | | tobacco Yes 2 | _ | the cause of death? | |
| Vital Record Sequence of the law requirements of the | | | | | | | 26 | Place of Deat | 24a. Was auto perf 1 Yes | ormed? | prior to death? | topsy findings available completion of cause of | |
| | of Vita Phyeician: this certific | To Be | examiner? 1 ☐ Yes 2 ☑ No | | ☐ ER/Outpatie | | Other: | | ome 5 🗷 Res | idence | 6 □Other (Spec | uty) | |
| | rision of | Certification: | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Newsielde 6 Could not be determined | 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At | home, farm, st | М | 28c. Injury at Work? 1 ☐ Yes | 2 □No | 28d. Describe | how inju | iry occurred | ral Route Number, | |
| | Divisit To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the | | 29a. Certifier 1 Certifying Phys | building, etc. (Specialist of the best of my ki | nowledge, deat | th occurred | at the time, d | ate and place. | City or To | wn, State | e) | stated | |
| | To the H within 24 To the F complete | Medical | 29b. Signature and title of certifier Penalth Affloys 0.0. 29c. License number H 5 2 3 6 5 | | | | | | | 29d. Date signed (Month, Day, Year) November 28, 2006 | | | |
| | Sta Registr | | 30. Name and address of person who con 4801 Dorsey Ha 31. Date filed (Month, Day, Year) NOV 2 9 2006 | mpleted cause of death (It | | Print) | Ellic | sHC; t | y Mar | land | 21042, | Ronald Jeffreys | |

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

| Plane U. Lewis | | 1- For State Certificate of Death Reg. No. 2005 3780 |
|---|------------------|---|
| Physicia | n/ | 1. Decedent's Name (First, Middle, Last) 2. Date of Death |
| Medical Examir | ner | 1)1 Ane - J LCw 15 November 19, 2006 1842 hrs |
| | | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Good Samaritan Hospital 4c. County of Death Baltimore |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or |
| Director | - | 344-66-8134 1 M 2 VF 63 Yrs. Months Days Hours Min. June 32, 1943 Country) N.C. |
| v any | ı | 10a. State 10b. County , 10c. City, Town or Location 10d Inside City Limits |
| daryland 28a-f show 1 at once. | ē | MD BALTIMORE PARKVIlle 1 Yes 2 LING |
| Mary or 28a- | irec | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? |
| vith the | 급 | 18 O CROM WOOD KD. 21234 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No. 14. Race - American Indian, Black, |
| death v | Funeral Director | 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc |
| after c | 징 | 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 UNo specify: Specify: Wh. Te |
| hours natur | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) |
| imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. | Completed | 12th No Assistant Poctors office |
| D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica | 3 | 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) |
| 2121 2121 ould be f Mental marked ic event, | Be | CHIELE TODD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| AD 2 2 shous and N 27 is m | 으 | Terri Grebel 941196 ELeu ST. Waipahu, HA 96 76 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State |
| e, North I and Health item | 1 | 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State |
| MOI Pages nent of ant: H | | Dackward Comtes (128 06 Ratto W. |
| Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other fraumati | 1 | 22 Name and Address of Facility FAUL STELLA FUNERAL HOME, PA 7527 harford RD. BALTO. MD 21234 |
| Physician | - | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval |
| /Medical | . 1 | *failure List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease Death |
| , Adminier | | or condition resulting in death) Due to (or as a consequence of): |
| Lun X * | ē | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): |
| | jä. | cause. Enter Underlying Cause (Disease or injury that initiated c. Due to (or as a consequence of): |
| outed nd rransit | EX | events resulting in death) Last Due to (or as a consequence of): d. |
| 760, freate be executed freate be executed freate be the physician and the burial - transit | Medical Examiner | UNPENDED AMENDED |
| 3760, ficate be g physic s the bur | _ | IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year |
| Box 68 e death certifi | sician | past 12 months? 4 Pregnant at time of death 5 Dther (Specify) |
| Bo he dear | Phys | 1 Yes 2 No 9 V Unknown 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |
| P.O s that t | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown |
| ds, equire | Completed by | 24a. Was an 24b. Were autopsy findings available |
| e law te has l | <u>m</u> | autopsy performed? performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No |
| al Re an: Th | | 25. Was case referred to medical 26 Place of Death (Check only one) |
| Vita hysicia this ce | To Be | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Other |
| Division of Vital Records, P.O. ral or Attending Physician: The law requires that the start cheath. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach | | 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred |
| Siol | icati | 2 Accident Investigation 28e Place of Injury - At home farm street factory office building etc. 28f Location (Street and Number or Rural Route Number City. |
| Divi | Certification: | 3 Suicide 6 Could not be determined (Specify) |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | | 29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 30a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 30a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. |
| To the within To the comp | Medical | and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) |
| | - | O.C.M.E. November 20, 2006 |
| | 1 | 30 Name and address of person who completed cause of death (Item 23a) |
| 7) | | Ana Rubio MDAssistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 |
| St Regist | ate | 31. Date filed (March, Day, Year) 32 degistrar's Signature |
| - Regist | الاند | A A A A A A A A A A A A A A A A A A A |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 1/ per in 2861 11-29-06 vt. State of Maryland Pepartment of Health and Mental Hygiene Reg. No. 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 Month Udva **Physician** ucas 28 8.15 AM lores /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Bultinure Ave. Apt. 3 803 Wabash If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 25 E Yrs. Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hygiene. Important: if Nem 27 is marked other than "naturel", or items 28a or 28e-f show eny Injury or other treumstic event, the Madical Examinar. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland 1 Yes 2 □ No altimore Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3803 Wabash Avenue Apartment 21215 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL Assistant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Austin Neally Lrene Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2438 Golders Green Court Windsor, MD. 21244 Wilbur Jr. Lucas 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland Dav 2016 Nordlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 23. Name and Address of Facility I lams Funeral Service, P. A alvin Baltimore, Maryland 21229 文 Les P.O. Box 11651 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Physician fmmediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner is certificate has been signed by the attanding physicien and director, paga 2 should be detached for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 TYGE To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this certifics completaly filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4□ Nursing Home Residence 6 □Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Let Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1

Registrar **DHMH 16 Rev 6/95**

State

ORIGINAL

301

Ggistrar's Signature

GATIMORIE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

OMBARDO

| | | | 1 - State Ragistrar | State of Marylan | | artment <i>rtificate</i> | | | Mental H | ygienę Reg. Né | nnc | 37806 | | |
|--|--|----------------|--|---|----------------------------------|--|-------------------|---|---------------------------------------|------------------------------|---|--|--|--|
| | Physici | | 1. Decedent's Name (First, Middle, Last) CASSANDRA R | LEAKE | | | | | 2. Date of Month | Death Da | | 3. Time of Death | | |
| | /Medic | | 4a. Facility Name (If not institution, give s | street and number) | | 4b. City, To | own, or l | Location of Dea | | | . County of Death | | | |
| | | 4 | Fort Washington | | | Ft. W | lash | inat.o. | 2 | | P. G. | | | |
| A. 15 | Funeral Director | | 5. Social Security Number 6. Sex 1579 - 02 - 3973 | 7. Age (In yrs. 40) | last birthday) Yrs. | If Under 1 Months | Year Days | Hours Mi | | Birth Day, Year) - 196 | 9. Birth Cou | place (State or Foreign intry) 5 h , D , C . | | |
| 50 | * | | Usual Residence of Decedent 10a, State 10b, County | 10c. Cit | y, Town or Lo | cation | | | - | | | 10d, Inside City Limits | | |
| Maryl | f sho | tor | D.C. | | ashin! | | | | | | | 1 ☐ Yes 2 ☐ No | | |
| 4 | r 28a | Director | 10e. Street and Number | I | | 10f. Zip C | Code | | | 10g. Cit | tizen of What Cou | intry? | | |
| the character of the | 238 | | 636 Alabama Ave | 2 S.E. | | | 002 | | | | S.A. | | | |
| III Z Z I Z I 3-0030 he filed within 72 hours effer death with the Manuland | a should be men within 12 hours are needs with the waysa. A should Mental Hygiene. I marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner result by notified at | by Funeral | 11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: | ĺ | Was Decede If Yes, specif 1 ☐ Yes 2[| | panic Origin? , Mexican, Pue Specify: | (Specify Yes or orto Rican, etc.) | No- | 14. Race - Amer Black, White Specify: Bla | , etc. | | |
| 0500-C1 | atura leal E | | 15. Decedent's Edu | | | dent's Usual | | tion uring most of w | ndrina | 16b. K | (ind of Business/l | ndustry | | |
| Z Didi | .en "r | Completed | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use | retired) | ning most or n | UKING | | 1 :00 | | | |
| , poli | Hygier then the | | 12t.h 17. Father's Name (First, Middle, Last) | | Salo | <u>s</u> | | 18 Mother's N | ame (First, Mide | | odwill Surname) | | | |
| | ked o | To Be | 20hn Leake | | | | 1 | | Richo | | - | | | |
| Maryiand 2121 | ith and Mental 27 le marked o | - | 19a. Informant's Name/Relationship (Ty, Leslie Leake-Mo | | | | | | | | or Town, State, Zi | ip Code) | | |
| alumore, | permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked eny Injury or other traumatic evone. | | 20a. Method of Disposition 12 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 7 L. Lincoln Cem. | | | | | | | | | | | |
| | Departm Departm Imports eny Inju | | 21. Signature of Funeral Service License | 21. Signature of Funeral-Service Licensee 22. Name and Address of Facility Dunn & Sons 5635 Eads St, N. E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate | | | | | | | | | | |
| | 1961 V 2 | | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or | cations that caused the deat ne cause on each line. | h. Do not ent | er the mode | of dying | , such as cardi | ac or respiration | arrest, | | Approximate Intervat Between Onset and Death | | |
| | hysician /Medical xaminer | her | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a consequence). Huperten Huperten Due to (or as a consequence). | uence of): Sion | eart | Dis | oase | | | | | | |
| arobe executed | ohysicien and the burial-transit | dicai Examiner | Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conseq | uence of): | | | | | | | | | |
| 00 | ng phys | Medi | IF FEMALE: | | | | | _ | | | 1 | | | |
| D. DOX O | the attending p | Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 M No 9 Unknown | 3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown | Ideath 3[| ∃Ectopic prec ∃Other (spec | | | | - | 23d. Date of delivery Month Day Year | | | |
| ا و | signed by the a | þ | Part II. Other significant conditions cor | ntributing to death but not res | ulting in the u | nderlying cau | use give | n in Part I. | 1 | d tobacco | | the cause of death? | | |
| VIIAI RECORDS, | a has been signed to ge 2 should to | Completed | | | | | | | pe | topsy rformed? | prior to death? | opsy findings available ompletion of cause of | | |
| | | 0 | 25. Was case referred to medical | | | | | 26. Place of D | 1 ☐ Ye eath (Check on | | 1 Yes | 2 No | | |
| Noise Par | nis certificete has | ToB | eyaminer? | lospital: 1 Inpatient 25 | ER/Outpatier | nt 3 DOA | Othe | | | | 6 □Other (Spec | ıfy) | | |
| | after death. Director: After th | | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time o Injury | f 28 | c. Injury Work | at ? es 2 □ No | 28d. Descrit | e how inju | iry occurred | | | |
| DIVISION OF | ours after des erst Director filled in by th | Certification: | 3 Suicide 6 Could not be determined | 28e. Ptace of Injury - At h building, etc. (Special | ome, farm, sti fy) | reet, factory, | office | | 28f. Location City or | (Street a | nd Number or Rui e) | ral Route Number, | | |
| 900 | F T T S | edical (| 29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin | sician: To the best of my kno ner: On the basis of examina and manner stated. | owledge, deat ation and/or in | h occurred at vestigation, i | t the timi | e, date and pla inion, death oc | ce, and due to t curred at the tim | ne cause(s e, date an | s) and manner as id place, and due | stated. to the cause(s) | | |
| 1 | within 2 To the | Me | 29b. Signature and Itle of certifier | HD | | | | number 65 – hl (), . | sh.D.C. | 29d. Da | ate signed (Month | , Day, Year) | | |
| / | 7 | | 30. Name and address of person who co | empleted cause of death (Ite/ | | | | - | | | | | | |
| Q | F | | Rumana Shamoom 1 | 7D 1011 Non | th Ca | rital | St | . N. W. | 20002 | | | | | |
| 100 | Sta Registi | | 31. Date filed (Month, Day, Year) | 32. Pagistrar's Signa | K A | medica | | | | | | | | |

| | | | For Stata | riease | • • | | d / Depa | artment of F ctificate of a | lealth and | - | /gien | 2006 | 37807 |
|----------------------------|---|------------------|--|------------------------------------|-----------------------|-------------------------------------|----------------|---|--|---------------------------------------|-----------------|---|------------------------------------|
| | | | Registrar | F - 1 14: 1 11 - 1 - | | | Cel | uncate or t | Dealit | 2. Date of D | Rag. N | 0. | 3. Time of Death |
| | Physicia | an | Decedent's Name (| First, Middle, La | ist) | | | | | Month | D | ay Year | |
| | /Medic | | LICHARD | E | METIU | | | | | Nev | 2 | | 7.30 AM |
| | Examin | er | 4a. Facility Name (If n | ot institution, gi | re street and nu | mber) | | 4b. City, Town, o | r Location of Deat | h | | c. County of Deat | |
| | | | Oakers: | F 1511 | ege | | | | kville | ., | | <u> Baltimo</u> : | |
| | Funeral | | 5. Social Security Nun | | Sex N 1∐AM 2□F | 7. Age (In yrs. | | If Under 1 Year Months Days | If Under 24 Hrs Hours Min. | (Month, D | ay, Year | 9. Birti | hplace (State or Foreign untry) |
| | Director | | 165-12-1 | /35 | | 86 | Yrs. | | | June | 17, | 1920 | PA. |
| | DC > | | Usual Residence of D 10a. State | Ob. County | | 10c Ci | ty, Town or Lo | cation | | | | | 10d. Inside City Limits |
| | aryla sho | _ | | | ore Co | i | rkvil | | | | | | 1 ☐ Yes 2 ☐No |
| | 889-1 | Š | | | 010 00 | • 14 | | | | | 10- 0 | 141 1 147 C- | -1-0 |
| | ier death with the Marylan Items 23a or 28e-f show Includet be notified at | Funeral Director | 10e. Street and Numb | | 1 | | | 10f. Zip Code | 1224 | | | itizen of What Co | |
| | ath v | ā | 8820 Wal | ruer B | | | | | 1234 | | | ted Sta | |
| | e de | rue | 11. Marital Status | | Armed Fo | edent Ever in U proes? | l.S. 13. | Was Decedent of Hi If Yes, specify Cuba | lispanic Origin? (S an, Mexican, Puer | to Rican, etc.) | 0- | Race - Ame Black, White | |
| 8 | or I | by Fi | 1 Never Married | | 1 X Yes If Yes, Gi | ve | | 1 □ Yes 2 🖽 o | Specify: | | | Specify: W] | hite |
| 215-0036 | within 72 hours after death with the Maryland ene. Than "netural", or tems 23a or 28e-f show tre Mardical Examinar must be motified at | | 3 Widowed 4 | | Year or D | rates: | 160 Dass | dont's Havel Oncor | ation | | 16h | | |
| γ̈́ | net "net | Completed | (Specify | 5. Decedent's E only highest gi | ade completed) | | (Give | dent's Usual Occup kind of work done DO NOT use retired | during most of wo | rking | 160. | Kind of Business/ | industry |
| 7 | Mithi | ш | Elementary/Second | lary (0-12) | College (| 1-4or 5+) | | ding En | | | Ве | thleher | m Steel |
| N. | be filed within 72 hours aft Ital Hygiene. Id other than "netural", or event, Ital Medical Exam | | 1.2 17. Father's Nam <i>e (Fi</i> | irst Middle Las | 04 | | MET | aring En | 18. Mother's Na | me (First, Middle | e Maide | n Sumame) | |
| <u> </u> | tal + | Be | Herman E | | | | | | | a K. D | | | |
| Maryland | s 1 and 2 should be of Health and Menta liem 27 is marked other traumatic ev | ဥ | | (D. J. C bi- | Comman Order | | 10h Maid | a Address (Ctroot | | | | | Zip Code) 21234 |
| Jai | 2 sho | | 19a, Informant's Nam | • | | i fo \ | 1 | • | | | | | 2.201 |
| | l and lealth om 27 her tr | | Mrs. Edi | | rus (w | | _ | Walthe | | Date Date | | ocation - City or | |
| 9 | | | 20a. Method of Dispo 1 ☐ Burial 2 🔼 | | ☐Removal from | State 300. | cemetery, cre | sition (Name of natory or other place | C) 1 | NOV. 30, | | | |
| Ē | Pages ment of ent: If it ury or o | | `4 □Donation 5 | | | EV | | uneral | | 2006 | _ | | Hill, MD. |
| Baltimore, | permit. Page Department of Importent: If any injury or once. | | 21. Signature of Fund | eral Service Lice | | - 0 | F. | Name and Addre | ss of Facility | hapel& | Cre | mation | Services |
| 10 | 80 = 99 | | 1/14 | my 1 | 100 | n,h | ` 8 | 800 Har | ford Ro | Par | kvi | lle.MD. | 21234 |
| | | | 23a. Part 1. Enter the | disease, or cor | mplications that | caused the dea | th. Do not en | er the mode of dyir | ng, such as cardia | c or respiratory | arrest, | | Approximate Interval Between |
| | Pnysician | | Immediate Cause (Fi | | Α. | CCVIS |) | | | | | | Onset and Death |
| | /Medical | | resulting in death) | - | a. Due to | (or as a consec | quence of): | | | | | | Yeur |
| | Examiner | | | [| | | | | | | | | |
| | | ē | Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in | nediate | Due to | (or as a consec | quence of): | | | | | | |
| , | uted d ansit | Examiner | Cause (Disease or in that initiated events | jury | C. | | | | | | | iii | |
| o · | e be executed /sician and e burial-transit | Exa | resulting in death) La | st | Due to | (or as a consec | quence of): | | | | | | |
| 760, | re be ysicia e bur | cal | | • | d | | | | | | | | |
| 9 | leath certificate attending phys I for use as the | Physician/Medic | | - | | | | | | · · · · · · · · · · · · · · · · · · · | | | |
| Вох | ndin use | N/ | IF FEMALE; 23b. Was decedent p | pregnant | | tcome of pregn | | 75 | | | | 23d. Date of deli | , |
| ň | death atte | cia | in the past 12 m 1 ☐ Yes 2 ☐ | ionths? | 4□Prøg | birth 2 ☐ Feta nant at time of c | |]Ectopic pregnancy] Other (specify) _ | y | | | Month | Day Year |
| P.O. | the cy the | SÁL | 9 🗆 Unknown | | 9□ Unkr | own | | | | | | | |
| J. | The law requires that the death certificate ate has been signed by the attending phys page 2 should be detached for use as the | Y P | Part II. Other signific | | | | | nderlying cause give | ven in Part I. | 23e. Did | tobacco | use contribute to | the cause of death? |
| S D. | sign Id be | d by | Benent | ric. | CHF | CV | A . I- | TN | | 1 🗆 |] Yes | 2 10 3 Pr | obably 4 □Unknown |
| Ö | A req | ete | | * | , | | (| | | 24a. Wa | san | 24b. Were au | topsy findings available |
| ě | has ge 2 | Completed | | | | | | | | per | opsy formed? | death? | completion of cause of |
| <u></u> | n: The | | | | | | | | 00 81 (19 | 1 Yes | | lo 1 Ll Yes | 2 No |
| Ħ | icertif certif recto | Be | 25. Was case referre examiner? | | Hospital: | | 7500 | oth | | ath (Check only | | a (7)011 (0 | " 1 |
| 5 | Phys this al di | 10 | 1 ☐ Yes 2 ☑ N 27. Mann Death | 0 | 28a. Date | Inpatient 2 | 28b. Time o | | 100 | 28d. Describe | | 6 □Other (Spec | city) |
| Ę | ling After fune | o | 1 Natural | 5 Pending | (Mor | nth, Day Year) | Injury | Wor | rk? Yes 2∐No | | , | | |
| S | teath death tor: the | cat | 2 ☐ Accident 3 ☐ Suicide | investigati 6 ☐ Could not | be as Bles | o of Injuny - At h | ome farm et | reet, factory, office | | 28f Location | (Street a | and Number or Ri | ıral Route Number, |
| Division of Vital Records, | or Al | Certification: | 4 Homicide | determin <i>e</i> | d 200. Flac build | ling, etc. (Speci | ify) | leet, factory, office | | City or To | | | 74111001011001, |
| _ | urs a | | 20a Castilas | Complete and I | Noveleines To th | a bast of mucks | owladge deal | h occurred at the ti | mo data and plac | a and due to the | 0 021150/ | e) and manner ac | etated |
| | To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely illed in by the funeral director, page 2 | Medical | | | aminer: On the I | | | vestigation, in my | | | | | |
| | the the | Med | 29b. Signature and ti | tle of certifier | and mai | mer stateu. | | 29c. Licens | se number | | 29d. D | ate signed (Monti | h. Dav. Year) |
| | 2 ₹ 2 8 | - | 290. Signature and th | | - 100 | | | | | | | | |
| 7 | | | , / | 1 | | | | | , , , | | 100 | rent 90 | 2000 |
| | 1241 | | 30. Name and addres | ss o per on wh | o completed cau | se of death (Ite よよう | | | 0.1 | .11. | \sim | 0 212 | 1h 2006 |
| | 10 | | J=+F | Lond | 1 mm | | W 6. 19 | W B1-3 | Pes t. | V112 | 1 = 11 | 01- | - 1 |
| | | ate | 31. Date filed (Month | , Uay, Year) | 32. | gistrar's Sign | ature | and . | | | | | |
| | Regist | air | I N | IUV Z 9 | 2006 | Experient. | 15 19 | | | | | | - |

| | | | | State of Maryland | | | Mental Hy | giene | 0 7 0 0 0 |
|---|--|----------------|--|--|---------------------------------------|--|--------------------------------------|---------------------------------|--|
| | | • | State Registrar | | Certifica | ite of Death | | Reg. No.2006 | 37808 |
| | D I1-1- | | Decedent's Name (First, Middle, Last) | A 041 | | | 2. Date of De | ath Day Year | 3. Time of Death |
| | Physicia /Medica | | DOROTHY C. | MC PHER | SON | | Nover | nber 25, 200 | 6 4:38PM |
| | Examine | | 4a. Facility Name (If no institution, give st | reet and number) | 4b. Cit | y, Town, or Location of Dea | h | 4c. County of Dear | |
| | | J | Franklin Square | Hospital Cel | nter 1 | Rosedale | | Balti | more |
| | Funeral | | 5. Social Security Number 6. Sex | 7 Ane /In ure las | t birthday) If Und | ler 1 Year If Under 24 Hrs | | th O Dia | hplace (State or Foreign untry) |
| - 8 | Director | | 215-42-9055 | M 2×F 64 | Yrs. | S Days Hours IVIII | 06/01 | 1942 MAI | RYIAND |
| | p . | - | Usual Residence of Decedent 10a. State 10b. County | 10a Cib. 3 | Town or Location | | | | / |
| | aryla •hov | _ | 10a. State 10b. County | | | _ | | | 10d. Inside City Limits 112/Yes 2 □ No |
| | Ba-f | cto | MARYLAND | 1.5 | BALTIMO | | | | ^ |
| 20 | with the Maryland a or 28a-f ehow be notified at | Director | 10e. Street and Number | | 10f. 2 | Zip Code | | 10g. Citizen of What Co | |
| 2 | death with the Maryland ms 23e or 28e-f ehow | | 6010 HAMILTON | AVENUE | | 21237 | | U.S.A | |
| + | tems | Funeral | | Was Decedent Ever in U.S. Armed Forces? | 13. Was Dec | edent of Hispanic Origin? (Specify Cuban, Mexican, Puer | Specify Yes or No to Rican, etc.) | - 14. Race - Ame Black, Whit | |
| 98 | s afte | by Fi | 1 Never Married 2 Married | 1 ☐ Yes 2 No If Yes, Give | 1 ☐ Yes | 2 No Specify: | | Specify: B | LACK |
| 0 F € | within 72 hours after ane. than "natural, or ite he Medical Examina | o O | 3 Widowed 4 Divorced | Year or Dates: | | /- | | | |
| 5.0 | nat | Completed | 15. Decedent's Educ (Specify only highest grade | completed) | 16a. Decedent's Us (Give kind of w | sual Occupation vork done during most of wo 'use retired) | rking | 16b. Kind of Business | Industry |
| 7 2 | Mithir then | Ē | Elementary/Secondary (0-12) | College (1-4or 5+) | | WIFE | | Home MA | KER |
| -2 | D D T | ပိ | 17. Father's Name (First, Middle, Last) | | 1100002 | | me /First Middle | , Maiden Sumame) | |
| | ntal Hy ed oth | To Be | CORNELIUS | 11/10/201 | | | _ | , | |
| S 5 | J Me | ٩ | | | 105 11-22- 11-2 | ss (Street and Number or R | ty PR | | 7 2 11 27 . 2 27 |
| 「Son Maryland | l 2 st h and r ie n | - 1 | 19a. Informant's Name/Relationship (Typ | e, Printi) | 19b. Mailing Addre | ss (Street and Number of H | - O A | er, City or Town, State, I | 210 Code) Z /23/ |
| 2 7 2 | 1 and 1 eelt 1 eelt 1 mm 2 | | ISAIAH MCPhER 20a. Method of Disposition | SON HUSBAND | 6010 H | AMILTON HV | Data | 7/MORE MI | Town State |
| $\Lambda \subset P h \mathcal{C}$ Baltimore | Pages nent of hunt: if its | | 12 Burial 2 ☐ Cremation 3 ☐ Re | moval from State | netery, crematory or | rother place) | | 200. Location - City of | 10wii, State |
| <u>₽</u> - | . Pa tmen tant: jury | J | 4 ☐ Donation 5 ☐ Other (Specify) | MAR | YLAND NA | IT'L CEME. 1 | 2/2006 | LAUREL, | MARYLAND |
| Sall C | permit. Pages Depertment of Important: if i eny injury or once. | | 21. Signatur of Funeral Service Lices | | 22. Name | TL COME. and Address of Facility The Company of th | e DERI | RICK C. JO | ones FIH, |
| ≥ " | 2 □ E • 0 | | Juntte | / | MARY | 1And 2121: | 5 | 7 10112 / | THURE, |
| | | | 23a. Part1. Enter the disease, or compact shock, or heart failure. List only on | ations that caused the death. | Do not enter the mo | ode of dying, such as cardia | c or respiratory a | rrest, | Interval Between |
| | Physician | ı | tmmediate Cause (Final disease or condition | Massive. | Acute P | Ulmonary | Em bo | ilism | 2hours |
| | /Medical | | resulting in death) | Due to (or as a consequer | nce of): | M. T. T. O. T. G. T. G. | 011100 | 71.07.1 | 0-1700012 |
| | Examiner | | Conventially list and divine | | | | | | |
| | | Je. | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a consequer | nce of): | | | | |
| | outed ransit | Examine | Cause (Disease or injury that initiated events | | | | | | |
| ó | | | resulting in death) Last | Due to (or as a consequer | nce of): | | | | |
| 8760, | cete be execut physicien and the burial-trar | dicai | d. | | | | | | |
| 9 | | ed | | | | | | | |
| Вох | leath certifii ettending p | Physician/Me | 230. Was decedent pregnant | c. If yes, outcome of pregnance | | Programa | | 23d. Date of del | ivery |
| | deat e ett | 2 | in the past 12 months? 1 □ Yes 2 □ No | 4 Pregnant at time of deat | | | | Month | Day Year |
| P.0 | by the de | hys | 9 Unknown | 9□ Unknown | | | | | |
| | | P P | Part II. Other significant conditions cont | ributing to death but not resulti | ng in the underlying | cause given in Part I. | 23e. Did t | obacco use contribute to | the cause of death? |
| ž | w require been sig | | | | | | 10 | Yes 2⊡No 3⊡Pr | obably 4 Durknown |
| Division of Vital Records, | s bee | ompieted | | | | | 24a. Was | an 24b. Were au | Itopsy findings available |
| æ | The lav | Ĕ | | | | | | psy prior to death? | completion of cause of |
| a | | ပ္ | 25. Was case referred to medical | | | 00 81/ 0 | 1 Tes | | 2 No |
| ⋚ | | Ö | examiner? | ospital: 1 ☐ Inpatient 2 UEF | Wortestiant 20 r | Other | ath (Check only o | | |
| ŏ | Phys ral di | - 1 | 27. Manner Toeath | The second secon | VOutpatient 3□ [Bb. Time of | 28c. Injury at Work? | | dence 6 Other (Spen | ony) |
| e e | ding Ph. After thi tuneral | ğ | 1 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day Year) | Injury M | Work? 1 ☐ Yes 2 ☐ No | | | |
| | I or Attending after death. Director: After in by the fune | Certification: | 3 Suicide 6 Could not be | 28e. Place of Injury - At home | e, farm, street, facto | | 28f. Location / | Street and Number or Ru | ural Route Number |
| Š | after Dire | ert | 4 Homicide determined | 28e. Place of Injury - At home building, etc. (Specify) | | ,, | City or To | wn, State) | |
| _ | | | 29a. Certifier 1FC Certifying Physi | cian: To the best of my knowle | edge, death occurre | ed at the time, date and place | and due to the | cause(s) and manner as | etated |
| | 24 h Fur etely | edical | (Check only 2 Medical Examinations) | er: On the basis of examination and manner stated. | n and/or investigation | on, in my opinion, death occ | urred at the time, | date and place, and due | to the cause(s) |
| | within 2 To the complet | Ş Ş | 29b. Signature and title of certifier | | 2 | 9c. License number | | 29d. Date signed (Mont | h, Day, Year) |
| | F ≤ F ŏ | | 1/10 | 10 (_ | 4 | DECHIAC | | | |
| | < | } | 20 Name and address of several states | polylogical days the | 30) Wyon Brief | N 74068 | | November nore, Md 2 | x x 5, 2006 |
| | 1) | | 30. Name and address of person who con | / / | | auga Drive | 2.11 | 21/7 | 1220 |
| | Stat | | 31. Date filed (Month, Day, Year) | 32. Registrar's Signatur | nKlin Sq | juare Dive | DU IT | 1105e, 196 L | 1651 |
| | Registra | | 2001 0 0 0000 | Kedus & | Appelle | | | | |

| | | | For State Registrar | State of | Marylan | | | | d Mental Hy | giene | • | | | | | |
|----------------------------|--|------------------|---|---|---------------------------------------|-------------------------------------|---|------------------------------------|--|------------------------------------|---|-----------------------------------|-------------------------|--|--|--|
| | | | | 24) | | Cei | rtificate of L | Death | | Reg. No. | 2006 | -37 | 809 | | | |
| В | Physicia | | Decedent's Name (First, Middle, Las Samuel | st) | McKen | zie | | | 2. Date of Dea Month November | Day | 4, 2006 | 3:28 | P M | | | |
| 5 | /Medic Examin | | 4a. Facility Name (If not institution, give | street and numl | | | 4b. City, Town, or | Location of De | | | County of Deat | | | | | |
| | | | 2011 Shore Road | | | | Dundalk | | | | Balti | more | | | | |
| 11 | Funeral Director | | 097-10-3932 | ex 7 Mi 2□F | . Age (In yrs. I | | If Under 1 Year Months Days | If Under 24 H Hours N | drs. 8. Date of Birt (Month, Da August 1 | h 1, Year) 1,19 | 9. Birth Co New | nplace (State untry) Y York | or Foreign | | | |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Lo | cation | | | | | 10d. Inside | City Limits | | | |
| | Maryl -f sho ied a | tor | Maryland Baltimo | re | | Dundal | k | | | | | 1 □ Y€ | es 2 🕅 No | | | |
| | h the or 28a o notif | irec | 10e. Street and Number | | | - uriour | 10f. Zip Code | | | 10g. Citi | izen of What Co | untry? | | | | |
| | th wit 23a c ust be | al D | 2011 Shore Road | | | | 21222 | 2 | | | USA | | | | | |
| | er dea tems ner m | Funeral Director | 11. Marital Status | 12. Was Deced | es? | S. 13. | Was Decedent of Hi If Yes, specify Cuba | ispanic Origin? an, Mexican, Pu | ? (Specify Yes or No- uerto Rican, etc.) | | Race - Ame Black, White | | | | | |
| 36 | rs afte | by F | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 1X Yes 2 If Yes, Give Year or Dat | 2∐ No : :es; | | 1 □ Yes 2X No | Specify: | | | Specify: Wh | ite | | | | |
| 21215-0036 | within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at | ted | 15. Decedent's Ed | lucation | | 16a. Dece | dent's Usual Occup | ation | dita | 16b. Ki | ind of Business/ | ndustry | | | | |
| 21 | ithin 7 ne. nan "n | Completed | (Specify only highest gra | College (1-4 | 4or 5+) | | kind of work done o DO NOT use retired | during most or 1) | working | | | | | | | |
| | led with the led w | Co | 12 years 17. Father's Name (First, Middle, Last) | 1 year | | | Painter | 19 Mothor's I | Nama /First Middle | | rlines | | | | | |
| Maryland | d be fi | Be c | William H. McKenz | | | | | | . McCullur | me (First, Middle, Maiden Surname) | | | | | | |
| ary | shoul | ᅀ | 19a. Informant's Name/Relationship (| | | 19b. Mailir | | | | er, City or Town, State, Zip Code) | | | | | | |
| | and 2 salth a 27 is er trai | | Patricia McKenzie | Daugh | iter | 2011 | Shore Roa | id, Dune | dalk,Maryl | Land | 21222 | | | | | |
| ore | of He | | 20a. Method of Disposition 1 Burial 2 Cremation 3 | Removal from S | 20b. P | lace of Dispo emetery, crei | sition (Name of matory or other plac | | veniber | | ocation - City or | | | | | |
| Baltimore, | Pages tment of I tant: If it | | 4 □ Donation 5 □ Other (Specif | 1) | Bay | • | Crematory | | , 2006 | | timore (| | MD. | | | |
| Ba | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Ignature of Fune a Service Licer | m | elli | ν $\frac{\partial}{\partial x}$ | onnelly F 110 Solle | uneral ers Poi | Home Of I | ounda ounda | alk,P.A. | 2122 | 2 | | | |
| 7 | | | 23a. Part1. Enter the disease, or com shock, or heart failure, vist only | plications that car one cause on ea | used the death | | | | | | | Approxim Interval B | ate etween | | | |
| 8 | Physician | | Immediate Cause (Final disease or condition | _a | 000 | stay | le Con | ncer | | | | Onset an | d Death | | | |
| | /Medical Examiner | | resulting in death) | Due to (o | r is a consequ | uence of): | | | | | | 0 | | | | |
| Ŀ | | ē | Sequentially list conditions, if any leading to immediate | b. Due to (o | r as a consequ | uence of): | | | | | | | | | | |
| \$ | cuted id ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | C. | | | | | | | | | | | | |
| 2,0 | e exerian ar | | resulting in death) Last | Due to (o | r as a consequ | uence of): | | | | | | | | | | |
| 68760,76 | icate be executed physician and the burial-transit | dical | | ⊾d | | | | | | | | | | | | |
| | certifii Iding p | /Me | IF FEMALE: | 23c. If yes, outco | ome pf pregna | incy | | | | | 23d. Date of deli | Verv | | | | |
| . Box | death e atter d for u | Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No | 4 <u>□</u> Pregna | th 2□Feta nt at time of d | | ∃Ectopic pregnancy ∃Other <i>(specify)</i> | ′ | | | Month | Day | Year | | | |
| P.O. | at the by the | hys | 9 Unknown | 9□Unknov | | | | | | | | | | | | |
| ls, l | The law requires that the death certifite has been signed by the attending age 2 should be detached for use as | by | Part II. Other significant conditions of | ontributing to dea | ith but not resu | ulting in the u | nderlying cause give | en in Part I. | | | ise contribute to ☑No 3☐ Pr | | | | | |
| Ö | requi | Completed | | | | | | | _ // | | | | | | | |
| Rec | has t ge 2 s | mpl | | | | | | | — 24a. Was autop | | 24b. Were au prior to death? | topsy finding ompletion of | s available cause of | | | |
| <u>ra</u> | | ပ္ပ | 25. Was case referred to medical | | | | | 26 Place of I | 1∏ Yes Death (Check only o | 2 1No | | 2□ No | | | | |
| Ž | S S | To Be | examiner? | Hospital: 1 ☐ In | patient 2□ | ER/Outpatier | nt 3 DOA Othe | or: | g Home 5 Resid | | 6 □Other (Spec | eifv) | | | | |
| 0 | ng Phr ter thi | | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of | Injury , Day Year) | 28b. Time o | f 28c. Injun Worl | | 28d. Describe h | | | ,, | | | | |
| Sio | Attending r death. ector: After by the funer | catic | 2 ☐ Accident investigation | | | | M 1□ | Yes 2 □ No | | | | | | | | |
| Division or Vital Records, | I or Att after d Direct | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | Zoe. Flace C | of injury - At ho g, etc. (Specif) | ome, farm, str V) | eet, factory, office | | 28f. Location (S City or Tox | Street an n, State | d Number or Ru) | ral Route Nu | ımber, | | | |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Medical Co | (Check only 2 Medical Exam | niner: On the bas | sis of examina | tion and/or in | vestigation in my o | minion death o | lace, and due to the occurred at the time, | date and | Inlace and due | to the cause | e(s) | | | |
| | ormple | Mec | 29b. Signature and title of certifier | and manne | or stated. | | 29c. License | e number | | 29d. Dat | te signed (Monti | n, Day, Year) | | | | |
| | r s r ö | | M Anthon | , Rut | 7 . v | 0 | 023 | 1205 | | No | vente | 27, | 2006 | | | |
| | 0, | | 30. Name and address of person who | completed cause | of death (Item | 23a) (Type, | Print) | C+ 0 | alto m | 1 - | | | | | | |
| | \ | | W. A. Riley | Gong | 670 | 1 M.C | horles | ST. Po | alto. m. | 4 S | 15004 | | | | | |
| DR | Sta | te | 31. Date filed (Month, Day, Year) | nns 32 Re | gistrar s Signa | 1. A. | ace! | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 27, 2006 **Physician** 8:30 a.^M Gwendolyn Marie Macomber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Lochearn FutureCare Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 215-24-4005 78 Director January 4, 1928 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 No Director Parkville Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 United States 7906 Ridgely Oak Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Avon Products** Salesperson 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Hecker ဥ Charles Schutz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John R. Macomber / Husband 7906 Ridgely Oak Rd. Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 12/02/2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Moreland Mem. Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 5305 Harford Road Baltimore, MD Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Renal End Stage disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4□Pregnant at time of death 9□Unknown Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Whiknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 Yes 2 No 2 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ №6 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar DHMH 17 Rev 1/2001 4 Homicide

laren

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

Medical

State

and manner stated.

25

32 Registrar's Signature

Jauen L. Balett, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0058676

Moin sweet, suite 200, Pristerstown MD 21136

29d. Date signed (Month, Day, Year)

NOVEMBER 28, 2006

Registrar

State

30. Name and address of person

31. Date filed (Month, Day, Year)

10755 Falls Road

NOV 2 9

2006

Suto 200 Lutherville MD 21093

TIMOTHY L. Krohe

no completed cause of death (Item 23a) (Type, Print)

32, Registrar's Signature

| | | | For State | State of | Marylan | | artment of H | | d Mental Hy | giene | 1000 | 27012 | |
|---|--|------------------|---|--|-------------------------------|------------------------|---|-------------------------|-------------------------------------|---------------------------------|-----------------------------------|---|--|
| ** | Physicia | an | Registrar Decedent's Name (First, Middle, MENDI | , | Ε. | | MORST | | 2. Date of D | eath | 4, 2006 | 3. Time of Death 12:28 PM | |
| | /Medic | | 4a. Facility Name (If not institution, | | | | 4b. City, Town, or | | | - | County of Death | 12.20 | |
| | | | 504 LIMERICK (| | Age (In yrs. I | act hirthday) | If Under 1 Year | LUTHER | | irth | | IMORE | |
| | Funeral Director | | 216-10-8750 | 1 M 2 □ F | 87 | Yrs. | Months Days | | 1 8. Date of B 1 0 1 / 0 5 | 71919 | Coul | place (State or Foreign htry) MD | |
| and | t t | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Lo | cation | | | | | Od. Inside City Limits | |
| Mary | a-fsho | tor | MD BALT | TIMORE | | LUTH | ERVILLE | | | | | 1 □Yes 2 No | |
| with the | a or 28 be not | Funeral Director | 10e. Street and Number 504 LIMERICK (| TDC1 E #20 | 11 | | 10f. Zip Code | 21093 | | 10g. Citi | zen of What Cou | ntry? USA | |
| death | ms 23a | neral | 11. Marital Status | 12. Was Deced | ent Ever in U. | S. 13. V | Was Decedent of H | | (Specify Yes or Nuerto Rican, etc.) | 0- | 14. Race - Americ | can Indian, | |
| IIIG Z IZ IS-UUSO be filed within 72 hours after death with the Maryland | n' Health and Mental hygiene i them 23a or 28a-f show them 27 is marked other than "natural", or flems 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | b | 1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced | | □No | | TYes, specify Cuba I⊡Yes 2.10 X No | Specify: | ueno nican, etc.) | | Black, White, etc. Specify: WHI7 | | |
| 72 ho | "natur edical] | Completed | 15. Decedent's (Specify only highest | Education grade completed) | | 16a. Deced | lent's Usual Occup kind of work done o OO NOT use retired | ation during most of | working | 16b. Ki | nd of Business/In | dustry | |
| withir | r than | dwo | Elementary/Secondary (0-12) | College (1-4 | lor 5+) | SALE | | •/ | | WHO | LESALE | | |
| be filed | lental Hygiene. ked other thar ic event, the M | Be | 17. Father's Name (First, Middle, La | ast) | | MODO | TEIN | | Name (First, Middle | e, Maiden | Surname) | CILECKY | |
| ₹ §: | and Mer is marke aumatic | ဥ | MAURICE 19a. Informant's Name/Relationshi | (Type. Print) | | _ | TEIN | ETHEL and Number of | r Rural Route Num | ber, City o | r Town, State, Zip | SILESKY | |
| | tealth ar m 27 is her trau | | ANNETTE MORSTE | | | | | CIRCLE | #201 - | LUTHE | RVILLE, | MD 21093 | |
| Pages 1 | - <u>-</u> | | 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | | ate | e <i>metery, cre</i> r | sition (Name of natory or other plac HEBREW | | Date ./27/2006 | | cation - City or To | | |
| permit. | Department Important: I any injury conce. | | 21. Signature of Juneral Service Li | censee Att | h | 1 | Name and Addre | | SOL LEVI IN ROAD - | | | , INC. MD 21208 | |
| | | | 23a. Part1. Enter the disease, or c shock, or heart failure. List o | omplications that can nly one cause on each | used the death ch line. | n. Do not ent | er the mode of dyir | g, such as car | diac or respiratory | arrest, | | Approximate Interval Between Onset and Death | |
| | ysician Nedical | | Immediate Cause (Final disease or condition resulting in death) | a Due to (o | COR | | ARTERY D | ISEASE | | | | | |
| Ex | aminer | | Sequentially list conditions. | b | | | | | | | | | |
| nted | nsit 1 | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (o | r as a consequ | uence of): | | | | | | | |
| o, execu | an and | Exal | that initiated events resulting in death) Last | CDue to (o | r as a consequ | uence of): | | | | | | | |
| cate be ex | physician and the burial-transit | dical | | d | | | | | | | | | |
| The law requires that the death certificate be executed | within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as: | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | th 2□Fetal nt at time of d | Ideath 3□ | Ectopic pregnancy Other (specify) | / | | 2 | 23d. Date of deliv Month | ery Day Year | |
| S, T | gned b be deta | by Pł | Part II. Other significant condition | - | th but not resu | ulting in the ur | nderlying cause giv | en in Part I. | | | | he cause of death? | |
| he law requires t | should | | | RTENSION AL FIBRILL | ATION | | | | | | | ably 4 □Unknown | |
| The law | cate has l | Completed | AIRI | AL FIDRILL | ATION | | | | 24a. Wa aut per 1□ Yes | s an opsy formed? 2 No | prior to co | ppsy findings available mpletion of cause of 2 ☐ No | |
| VILCII /sician: 7 | s certif director | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 🛪 No | Hospital: | patient 2 | ER/Outpatien | t 3□ DOA Oth | or: | Death (Check only | | S ∏Other (Speci | f _V) | |
| IVISION OF | fter this | on: To | 27. Manner of Death 1 Natural 5 □ Pending | 28a. Date of | | 28b. Time of Injury | | | 28d. Describe | | | <i>y</i> / | |
| tendi | death. :tor: A / the fu | icatic | 2 Accident investiga 3 Suicide 6 Could no | t be | f injury - At ho | me farm str | M 1 □ eet, factory, office | Yes 2□No | 28f Location | (Street an | d Number or Run | al Route Number, | |
| tal or A | rs affer al Direction by ed in by | Certification: | 4 Homicide determin | ed building | g, etc. (Specif) | <i>i)</i> | | | City or To | own, State |) | arriodio Numbei, | |
| To the Hospital or Attending Physician: | n 24 hou he Fune i pletely fil | edical | | Physician: To the base and manner | sis of examina | | | | | | | | |
| Tot | To t | M | 29b. Signature and title of certifier | elen | ~ | 0 | 29c. Licens | e number | , | | e signed (Month, | Day, Year) | |
| | 18 | 1 | 10. Name and address of person v | ho completed cause | death (liem | 23a) (Type, | 356 | . Par | COAIC | LR | d | | |
| स्ट १० १८ | Sta | | 31. Date filed (Month, Day, Year) | 32. Re | gistrar's Signa | ture | 1 4 | | | | <u> </u> | | |
| DHMH | Registr | | NOV 2 | 9 2006 | auc | A A | porce | _ | | | | | |

| | | | 1 - For State Registrer | State of Maryla | nd / Depa | artment of H rtificate of L | ealth and I Death | | ienez () (| 16 | 37813 |
|---------------------|---|----------------|--|--|------------------------------------|--|--|--|-------------------------------------|-------------------------|---------------------------------------|
| | Physicia /Medic | | Decedent's Name (First, Middle, Last, | | Iae | Novotny | | 2. Date of Deat Month NOV. | Day | Year 006 | 3. Time of Death 2:49 P M |
| , | Examin | | 4a. Facility Name (If not institution, give | street and number) | | 4b. City, Town, or | Location of Death | 1 | 4c. County of | f Death | |
| | | | Harford Memorial | Hospital | | Havre 1 | De Grace | | Hari | ord | Co. |
| H | Funeral Director | | 5. Social Security Number 6. Se 1215-14-4930 | 7. Age (In yrs | . last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Dec. 2 | Year) | Count | ace (State or Foreign ry) rland |
| | 9 | | Usual Residence of Decedent | | | | | | | | |
| | urylar irhow | _ | 10a. State 10b. County | 10c. C | ity, Town or Lo | ocation | | | | 10 | d. Inside City Limits |
| | Ba-f s | Directo | Maryland Harfor | d | | | Aberdee | n | | | 1 ☐ Yes 2X No |
| | or 2 | Dire | 10e. Street and Number | | | 10f. Zip Code | | 1 | 0g. Citizen of W | at Count | ry? |
| | death with the Maryland ms 23a or 28a-f show finust be coulding at | | 901 Barnett La | | | | 1001 | | United | | |
| 326 | should be filed within 72 hours after death with the Marylar vid Medial Hygians with Hygians was seen statusal; or flems 23a or 28a-f show marked other than "natural; or flems 23a or 28a-f show maile event, the Maylical Examiner must be notilised at | by Funerai | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 € No lif Yes, Give Year or Dates: | | Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2⁄⊡XNo | spanic Origin? (S) n, Mexican, Puerti Specify: | pecify Yes or No- o Rican, etc.) | 14. Race Black Specify: | - America White, e | itc. |
| ž | 2 hot | ted | 15. Decedent's Edu | cation | 16a. Dece | dent's Usual Occupa | ition | | 16b. Kind of Bus | | |
| ر 15 | nin 7. In 'n | Completed | (Specify only highest grad Elementary/Secondary (0-12) | completed) College (1-4or 5+) | (Give | kind of work done di DO NOT use retired) | luring most of wor) | king | | | , |
| 7 | d with | mo; | 8 Years | College (17401 54) | | Homemake | r | | Own I | Iome | |
| ᅙ | e filed ti Hygi other vent, | BeC | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nam | ne (First, Middle, M | Maiden Surname |) | |
| <u>a</u> | uld be Mental riked c | ToE | Charles Cole | | | | | Floren | ce Ruley | 7 | |
| Maryland 21215-0036 | 2 sho and h is ma | | 19a. Informant's Name/Relationship (Ty | | | ng Address (Street a | | | | | |
| 2 (i) | and lealth m 27 her ti | | Mrs. Jeanette Has | | _ | Leight Ro | ad Abin | and the same of th | | 2100 | |
| Baltimore, | Pages 1 ment of P ant: If ite ury or ot | | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) | emoval from State | cemetery, crer | sition (Name of natory or other place t. of Jes | | | 20c. Location - C | | wn, State Maryland |
| Balt | permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any njury or other traumatic events. | | 21. Signature of Juneral Service Licens | | | Name and Address Duda-Ruck 7922 Wise | | | | | .222 |
| | | | 23a. Part1. Enter the disease, or compleshock, or heart failure. List only of | cations that caused the dea | | | | | | | Approximate |
| | Physician | 1 | Immediate Cause (Final | | | | | | | | Interval Between Onset and Death |
| į. | /Medical | | disease or condition resulting in death) | Due to (or as a conse | nuence of). | ndrome | | | | | 3 days |
| | Examiner | | | Due to (or as a conse | aca tra | of who | cher | | | - | 3 days |
| | | ner | Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conse | quence of): | -01 111 | 200 | | | | 33 |
| | nd nd transi | Examiner | that initiated events | | | | | | | | |
| 58/6 0, | icate be executed physician and s the burial-transit | | resulting in death) Last | Due to (or as a conse | quence of): | | | | | | |
| ρ | ificate g phy as the | edicai | | | | | | | | | |
| O. Box | requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit | by Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ► No 9 ☐ Unknown | 3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown | al death 3□ | Ectopic pregnancy Other (specify) | | | 23d. Date Mont | | y Day Year |
| 7 | that the ded by | F. | Part II. Other significant conditions cor | tributing to death but not re | sulting in the ur | nderlying cause giver | n in Part I. | 23e. Did tob | acco use contrib | ute to the | cause of death? |
| g B | w requires that s been signed t should be deta | | Infections Coli | | | , , , | | 1 ☐ Ye | | | bly 4 □Unknown |
| Ö | - D 76 | ete | | | | | | 24a. Was ar | 24b W/ | ro auton | sy findings available |
| Vital Records, | has 3e 2 | ompieted | | | | | | autopsy | pri led? de | or to com ath? | pletion of cause of |
| <u>ra</u> | iiclan: Th certificate rector, pag | e C | 25. Was case referred to medical | | | | 26. Place of Dear | th (Check only one | | Yes 2 | 2 □ No |
| > | ysician: is certific director. | 0 8 | examiner? 1 Yes 2 No | ospital: |] ER/Outpatien | Othor | | ome 5 Reside | | (Specify) | |
| Division or | ding Ph I. After th funeral | ation: T | 27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury Work | | 28d. Describe ho | | | |
| DIVIS | Hospital or Atten Autors after deat Funeral Director: Itely filled in by the | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Injury - At h building, etc. (Special | | eet, factory, office | | 28f. Location (Str City or Town | eet and Number State) | or Rural | Route Number, |
| | Hospi 24 hou Funer etely fill | edicai (| 29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) | sician: To the best of my kneed on the basis of examination and manner stated. | owledge, death ation and/or inv | occurred at the time restigation, in my opi | e, date and place, inion, death occur | and due to the ca red at the time, da | use(s) and manr te and place, an | er as sta d due to t | ted. he cause(s) |
| | within To th compl | × | 29b. Signature and title of certifier | | | 29c. License | | 29 | d. Date signed (| | ay, Year) |
| | | | peasent of | holle no | | 7000 P | 8050 | | 11/24/ | 06 | |
| | 2 | | 30. Name and address of person who co Prashant Shukla | mpleted cause of death (Item M 0 15 5. Pa | m 23a) (Type, | Print) #400 Abe | irdeen 1 | ND 2100 | | | |
| | Sta Registra | | Prashant Shukla, 31. Date filed (Month, Day, Year) NOV 2 9 200 | 3. Registrar's Sign | ature for | de la | | | | | |

| 1- State of Maryland / Department of Certificate of | | | | | | | | | | ne N2 0 0 | 6 | 37814 |
|--|--|--------------------------|---|--|-----------------------|----------------------------------|--|--|--|---------------------------------|-------------------------|---|
| | | | Decedent's Name (First, Middle, L.) | .ast) | | | imouto or i | Journ | 2. Date of Death | | U | 3. Time of Death |
| • | Physici /Medio | | AUDREY GWEN | DOLYN (| ODELL | | | | NOVEMBER | Day 20 | 006 | 06:20 A M |
| | Examin | | 4a. Facility Name (If not institution, g | | | | 4b. City, Town, or | Location of Death | | 4c. County of | | |
| | | | GREATER BALTIMO | | | | TOWSON | Miller de a CAIII e | | BALTIMO | | |
| | Funeral Director | | 5. Social Security Number 6. 133-20-4269 | Sex 1 M 2 X F 7.7 | Age (In yrs. 82 | last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Ye July 29, | ar) | Count | ace (State or Foreign ry) Vordr |
| | | | Usual Residence of Decedent | | 02 | | | | July 29, | 1924 | IVEW | York |
| | nylan how | | 10a. State 10b. County | | | y, Town or Lo | cation | | | | 10 | d. Inside City Limits |
| | 8a-f | Director | Maryland Baltin | nore | | Cowson | | | | | | 1 ☐ Yes 2 📉 No |
| T | with the | 2 | 10e. Street and Number | | | | 10f. Zip Code | 1.006 | 10g. | . Citizen of Wh | | ry? |
| Q | leeth ns 23 | Funeral | 76 Cedar Avenue | 12. Was Deceder | nt Ever in U. | S. 13. V | | 21286 spanic Origin? (Spe | ecity Yes or No- | U.S. | | an Indian |
| Qg | or iten | Fun | 1 Never Married 2 Married | Armed Force 1 ☐ Yes 2¶ | s? | | | spanic Origin? (Spanic American, Puerto | Rican, etc.) | | White, e | |
| AUDR (1215-0036 | hours after deeth with the Maryland turet', or items 23a or 28a-f ehow at Examirar must be confibed at | d by | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give ² Year or Dates | | | □Yes 21XNo | Specity: | · | Specify: | Wh | ite |
| T-5 | "natu | Completed | 15. Decedent's (Specify only highest g | Education trade completed) | | (Give | ent's Usual Occupa kind of work done of OO NOT use retired | luring most of work | ing 168 | o. Kind of Busi | ness/Ind | ustry |
| , 21 | within 72 lene. than "nal | dwc | Elementary/Secondary (0-12) | 4 vears | | | | , ool Teach | ner | Educa | tion | |
| 75 | a filed I Hygi other | Be C | 17. Father's Name (First, Middle, Las | | | | | | e (First, Middle, Mai | | | |
| /ar | uld be Wenta wrked stic ev | To B | Joseph Ode | 211 | | | | Pear1 | F | leese | | |
| ELL Maryland | 2 should be filed v n and Mental Hygie ie marked other t raumatic event, ID | | 19a. Informant's Name/Relationship | (Type, Print) | | | | | al Route Number, C | | | |
| | 1 and Health em 27 ther tr | | Harvey L. Ode11 20a. Method of Disposition | | 20b P | | den Road | | 3 Lancas | ter, Pe | | |
| Baltimore | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 ie marked other than "naturei; or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examination must be invitibled at once. | | 1 ☐ Burial 2 [X]Cremation 3 4 ☐ Donation 5 ☐ Other (Spec | ☐Removal from State | te C | emetery, crem | atory or other plac | 9) | 20.04 | | | |
| | nit. Pertme | | 21. Signature of Funeral Service Lic | | GLE | | | tory 11-2 | | | | Maryland |
| ä | permit. Depertrimports eny inju | | Shone 1 P | un | | N | litchell-V 500 York | Wiedefeld Road Ba | Funeral Ltimore, 1 | Home, : | Inc. | 21212 |
| | | | 23a. Part1. Enter the disease, or co shock, or heart failure. List on | mplications that caus ly one cause on each | sed the death | | | | | | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | | | | OMYOPA | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | | as a conseq | • | | | | | | |
| | | 2 | Sequentially list conditions, | b. Due to for a | 20NAK as a consequ | y Acr | ery Dis | MSE | | | | |
| | uted d ansit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | co om 1 | 4 | | | | | |
| v oʻ | be executed icien and burial-transit | | resulting in death) Last | U | as a consequ | | | | | | | |
| 8760 | cate be executed ohysicien and the burial-transit | dlcal | | d | | | | | | | | |
| 9 | n certific | a | IF FEMALE: | 23c. If yes, outcom | | | | | | 1 | | |
| Bo | eath certif attending for use a | clan | 23b. Was decedent pregnant in the past 12 months? | 1□Live birth | 2 🗌 Fetal | death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of Month | | y Day Year |
| O. | it the de by the tached | ysl | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 9 Unknown | | | Curior (apociny) | | | | | |
| ر. ح | es that igned b | y P | Part II. Other significant conditions | | but not resu | ulting in the un | derlying cause give | n in Part I. | 23e. Did tobac | co use contribu | ute lo the | cause of death? |
| rd | w require been sig should b | edt | ATRIAL FIBAL | | | | | | 1 🗆 Yes | 2 No 31 | ☐ Proba | bly 4 □Unknown |
| Division of Vital Records, P.O. Box | Attending Physicien: The law requires that the death certific r death. ector: Atter this certificate has been signed by the attending petter; Atter this certificate has been signed by the attending py the funeral director, page 2 should be detached for use as | Completed by Physician/M | PULMONARY | | | | | | 24a. Was an autopsy | 24b. We | re autop | sy findings available pletion of cause of |
| <u>~</u> | : The law cate has page 2: | S | RESTRICTIVE | LUNG D | 1500 | E | | | performed 1 ☐ Yes 2 ☑ | l?, dea | ith? Yes 2 | |
| Vitt | icien: certific rector, | Be | 25. Was case referred to medical examiner? | Hospital: 1 Inpa | | | 3□ DOA Othe | r | (Check only one) | | | |
| o. | g Physical dispersion |): To | 1 ☐ Yes 2 🗹 No 27. Manner of Death | 28a. Date of In | itient 2 🗆 | ER/Outpatient 28b. Time of | 3□ DOA 28c. Injury Work | 7 | me 5 Residence 28d. Describe how i | | | |
| io | uttending death. ctor: After y the funer | atlor | 1 ■Natural 5 □ Pending 2 □ Accident investigate | 28a. Date of In (Month, I | Day Year) | Injury | | ? ′es 2 □ No | NA | . , | | |
| N. S | r Attender death rector: | Certification: | 3 ☐ Suicide 6 ☐ Could not determine | A 286. Place of I | Injury - At ho | me, farm, stre | et, factory, office | | 28f. Location (Stree City or Town, S | t and Number | or Rurai | Route Number, |
| | ris after or rai Dir | | | WA | | | | | NA | | | |
| | To the Hospitel or Atte within 24 hours atter de To the Funeral Direct completely filled in by th | Medical | 29a. Certifier 1 Certifying F (Check only 2 Medical Ext | Physician: To the bes aminer: On the basis and manner: | of examinat | wledge, death tion and/or inv | occurred at the time estigation, in my op | e, date and place, a inion, death occurre | and due to the cause ed at the time, date | e(s) and mann and place, and | er as sta I due to t | ted. he cause(s) |
| | To the within 2 To the comple | Z | 29b. Signature and title of certifier | ./ - | | | 29c. License | | 1 | Date signed (# | | ay, Year) |
| | | | Devens Q. | Nolaw us | 0 | | Dec | 25010 | - (| 1.25. | 20 | |
| | 12 | | 30. Name and address of person who SCRENA R. No. | and was | 8831 | SATYR | HILL RD | #100 PA | nevice, | NO 2 | 123 | 4 |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32. Regis | strar's Signa | Jonath 1 | | | | | | |

| | | | 1 - For State Registrar | State of M | laryland / Dep <i>Ce</i> | artment of He | | tal Hygier | Z 1111 h | 37815 |
|------------|---|------------------|---|---|---|--|---|--|--|---|
| | Physici /Medi | | 1. Decedent's Name (First, Mide | PUDLIN | | | | | Day Year 2006 | 3. Time of Death |
| | Examir | | 4a. Facility Name (If not instituti | on, give street and number |) | 4b. City, Town, or I | | | 4c. County of Deal | |
| | | | John Hopki | | | | If Under 24 Hrs. 8.1 | Date of Birth | NIF | |
| | Funeral Director | | 5. Social Security Number 216-03-0073 Usual Residence of Decedent | 6. Sex 7. A | ge (In yrs. last birthday Yrs. | Months Days | Hours Min. | Date of Birth Month, Day, Yea | 9. Bin | hplace (State or Foreign untry) |
| | land ow | | 10a. State 10b. Count | ty | 10c. City, Town or L | ocation | | | | 10d. Inside City Limits |
| | Man e-f sh | tor | Ms | NA | | BALTIMORE | | | | 1 Yes 2 No |
| | ith the | Dire | 10e. Street and Number | 0 - | | 10f. Zip Code | | 10g. (| Citizen of What Co | |
| | s 23e | erai | 11. Marital Status | EAST AUC | t Ever in U.S. 13. | | 1274 | Vac or No | U. S. | 7 |
| (0 | fter de ritem ineri | Funeral Director | 1 □ Never Married 2 □ Ma | Armed Forces | ? | | spanic Origin? (Specify , Mexican, Puerto Rica | n, etc.) | Black, White | |
| 5-0036 | 72 hours after death with the Maryland naturel', or items 23a or 28e-f show Jical Exeminat newst be notified at | d by | 3 ☐ Widowed 4 ☐ Divorce | od If Yes, Give Year or Dates: | HEMY. | 1 Yes 2 No | Specify: | | Specify: U | uh.te |
| 15-(| "natu | Completed by | 15. Decede (Specify only high | ent's Education lest grade completed) | (Givi | edent's Usual Occupat e kind of work done du DO NOT use retired) | irina most of working | 16b. | Kind of Business/ | Industry |
| 2121 | iene. r than " | dwo | Elementary/Secondary (0-12) | College (1-4or | 5+) | Fork LiFT | | L | ock Cor | ρ. |
| | ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23s or 28e-f show or other treumatic event, the Medical Eventinal rings the notified at | Be C | 17. Father's Name (First, Middle | e, Last) | ,,,,, | | 18. Mother's Name (Fin | st, Middle, Maid | en Sumame) | |
| yla | should be nd Mental marked o | 2 | UNKARUA | | r. | | UNKA | | | |
| Maryland | nd 2 sho atth and 27 is ma ir treuma | | 19a. Informant's Name/Relation | | | | AUC BAH | ute Number, City | | Tip Code) |
| | s 1 and 1 Health tem 27 other tr | 1.5 | 20a. Method of Disposition | ~ | | osition (Name of ematory or other place) | | | 入() スイソン Location - City or | Town, State |
| e E | Pages nent of int: If it | | 1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other | | , I ~ | D CEM, | 11/28/0 | 6 B | alte. MD | |
| Baltimore, | permit. Pages 1 al Department of Hea Importent: If item any injury or othe QDCB. | | 21. Signature of Funeral Service | e Licensee | d | 2. Name and Address | of Facility | Home, F | OP | |
| | | | 23a. Part . Enter the disease, | or complications that cause | d the death. Do not en | 7527 harf- iter the mode of dying, | such as cardiac or res | spiratory arrest, | x 1179 | Approximate |
| | Physician | | shork, or heart failure. List Immediate Cause (Final disease or condition | st only one cause on each | line. 6 206 | re. | | | | Onset and Death |
| | /Medical Examiner | П | resulting in death) | Due to (or a | s a consequence of): | | | | | 2 1 |
| | LXammer | _ | Sequentially list conditions, | b. — Due to (or a) | c. diFF. | c1.2 | | | | 2-3 days |
| | uted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | 1 | 3 d 001130qd31103 01). | | | | | |
| oʻ | ate be executed hysician and the burial-transit | | resulting in death) Last | Due to (or as | s a consequence of): | | | · | | |
| 8760, | ate be physici the bu | dicai | | d | | | | | | |
| 9 x | eath certific attending pl for use as t | Physician/Med | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome | | | | | 23d. Date of det | verv |
| . Box | that the death cer ed by the attendir detached for use | iciar | in the past 12 months? | 4☐Pregnant a | | □Ectopic pregnancy □ Other (specify) | | | Month | Day Year |
| P.0 | at the ded by the etached | Phys | 9 Unknown | 9□ Unknown | | - | | | | |
| Records, | es ign be | by | Part II. Other significant condi | tions contributing to death | but not resulting in the | underlying cause giver | n in Part I. | | | the cause of death? |
| ၀၁ခ | law requir as been s 2 should | Completed | | | | | | 24a. Was an autopsy | 24b. Were au | topsy findings available completion of cause of |
| <u>=</u> | The ate h page | Com | | | | | | performed? | death? | 2□ No |
| Vital | Physicien: this certifica | Be | 25. Was case referred to medic examiner? | He apital: | | Othor | 26. Place of Death (Ch | | | |
| of | Physer this eral di | n: To | 1 Yes 2 No | 28a. Date of Inj | ury 28b. Time of | III 300A | 4 Nursing Home | 5 L Residence Describe how in | | ify) |
| ion | Attending r death. ector: After by the fune | atio | L | tigation | ay Year) tnjury | | es 2□No | | | |
| Division | of or Atto after de Directo | Certification: | 3 Suicide 6 Coule 4 Homicide deter | mined 289. Place of Ir | njury - At home, farm, st tc. <i>(Specify)</i> | treet, factory, office | 28f. I | Location (Street City or Town, Sta | and Number or Ru ste) | ral Route Number, |
| | To the Hospitel or Attending & within 24 hours after death. To the Funerel Director: After completely filled in by the funer. | edical C | 29a. Certifier 1 Certify (Check only 2 Medical | ring Physicien: To the bes al Examiner: On the basis and manner s | of examination and/or in | th occurred at the time nvestigation, in my opi | a, date and place, and onion, death occurred at | due to the cause t the time, date a | (s) and manner as nd place, and due | stated. to the cause(s) |
| | To the To the compl | Me | 29b. Signature and title of certif | | | 29c. License | number | 29d. C | Date signed (Month | n, Day, Year) |
| | | | Adam | - (Posoner | Ms | | 25 - 000 | | 100 22. | 2006 |
| | 10 | | 30. Name and address of perso | n who completed cause of | death (Item 23a) (Type 4940 EAS | Print) TERA AVE | Balto A | 0 21 | 224 | |
| | Sta | ate | 31. Date filed (Month, Day, Yea | 1 | rar's Signature | A | 100 110 | | • | |
| | Regist | rar | NOV 2 | 9 2006 | w B. G | seed ! | | | | |

| | | | 1- State of Marylar Registrer | | artment of Health and rtificate of Death | | ene . No 2006 | 37816 |
|---------------------|---|----------------|---|----------------------------------|--|--|--|--|
| E | Physici | | 1. Decedent's Name (First, Middle, Last) LYDIA PRICE | | | 2. Date of Death | Day Year | 3. Time of Death |
| year | /Medic Examir | | 4a. Facility Name (If not institution, give street and number) 8702 C(MARRON CT. | | 4b. City, Town, or Location of De | ath | 4c. County of Deat | h |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (<i>In yrs.</i> 2/15 - 74 - 7/0/ 1 M 3 F 97 | last birthday) Yrs. | If Under 1 Year If Under 24 H Months Days Hours Mi | | 9. Birt | hplace (State or Foreign buntry) M) |
| | Maryland | or | Usuel Residence of Decedent 10a. State 10b. County 10c. Cit | ity, Town or Lo | PARKUIlle | | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| | with the | i Director | 10e. Street and Number 8707 (IMARROW CI | | 101. Zip Code 2 1 2 3 4 | 10g | . Citizen of What Co | • |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show many Injury or other traumatic event, I'm Madical Examinin must be notified at ance. | y Funeral | 11. Marital Status 12. Was Decedent Ever in U Amed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U Amed Forces? 1 □ Yes 2 □ No If Yes, Give | | Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1 ☐ Yes 2 ☑ No Specify: | (Specify Yes or No- erto Rican, etc.) | 14. Race - Ame Black, White Specify: | rican Indian, e, etc. |
| Maryland 21215-0036 | iin 72 hours n "natural" dedical Ex | Completed by | 15. Decedent's Education (Specify only highest grade completed) | 16a. Dece | dent's Usual Occupation kind of work done during most of w DO NOT use retired) | orking 16 | b. Kind of Business/ | |
| nd 212 | e filed with al Hygiene I other the vent, the | Be Com | Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) | | Housewife 18. Mother's N | ame (First, Middle, Mai | Itame . | |
| arylaı | should b and Menta a marked umatic e | ToE | Edward Tormollen 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailir | an Address (Street and Number of | ine JACO Rural Route Number, C | Character Contract | Zip Code) |
| | s 1 and 2 if Health a Item 27 is | | JANET Nelson 20a. Method of Disposition 20b. F | 172 | Desirion (Name of matory or other place) |). B. 1. fo . 1. Date 200 | 10 21239 c. Location - City or | Town, State |
| altimore, | nit. Pages artment of I ortant: If Its Injury or o | | 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee | dens of | - Faith Cen. | 27/06 R | osedale, 1 | MS |
| 88 | permit. Departr Importe any Inju | 0 0 | Jaul M. Stella 23a. Pan1. Enter the disease, or complications that caused the deat | th. Do not on | Name and Address of Facility Aul STELLA Funes 527 hayford Ro | · Balto. MI | 21234 | |
| | Physician /Medical | | shock, or heart failure. List only one cause on each line. | | e Hemt Pe | .) | | Approximate Interval Between Onset and Death |
| | Examiner | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | juerice of). | | | | |
| 8760, | s be execting sician end burial-transit | dical Examiner | Cause (Disease or injury that initiated events resulting in death) Last | uence of): | | | | |
| O. Box 68 | requires that the death certificate be execting requires that the deanding physician end hould be detached for use as the burial-tran | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12_months? 1 □ Yes 2 ⊇ No 9 □ Unknown IF FEMALE: 23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown | ıldeath 3 [| Ectopic pregnancy Other (specify) | | 23d. Date of deline | very Day Year |
| rds, P. | quires that the de n signed by the e uld be detached t | d by Ph | Part II. Other significant conditions contributing to death but not result. | ulting in the ur | nderlying cause given in Part I. | 23e. Did tobac | co use contribute to | the cause of death? |
| Vital Record | has the | Completed by | Kyperdens ion | | | 24a. Was an autopsy performed | prior to c death? | topsy findings available ompletion of cause of |
| | cian: ertific ector, | To Be C | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 | ER/Outpatien | 1 04- | eath Check only one) | | |
| Division of | ing After une | | 27. Manner of Death 1 Shatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | | 28d. Describe how i | | iry) |
| DIX | 2 5 5 5 | Certification; | 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At ho building, etc. (Specify | ome, farm, stre | eet, factory, office | 28f. Location (Stree City or Town, S | t and Number or Rui tate) | ral Route Number, |
| | To the Hospital or within 24 hours afte To the Funeral Dir completely filled in | fedicai | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my known and manner stated. | wledge, death tion and/or inv | vestigation, in my opinion, death occ | e, and due to the causeurred at the time, date | e(s) and manner as and place, and due | stated. to the cause(s) |
|) | 6 ± € 6 | × | 29b. Signature and title of certifier Mush Gell | | 29c. License number | 29d. | Date signed (Month | Day, Year) |
| | 5 | | | 7503 | Print) | Eusen M | 1 2120 | 4 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 2 9 2006 | ture A | house | | | |

Please Type or Print in Black Indelible Ink

Leonard Pendelton State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) Physician/ 2 Date of Death Month Day November 27, 2006 Medical Examiner endel ton 1125 hrs ernard 4a Facility Name (if not institution, give street and number 4c. County of Death Bon Secours Hospital NA Baltimore 5. Social Security Number 8 Date of Birth(MM/DD/YYYY) 9 Birthplace (State or **Funeral** Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. Director 220-68-6262 Months Davs Hours Min oreign 1 ×M 2 Country) MD May Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d Inside City Limits NA MD Baltimore 28a-f show 1 XYes 2 No , or items 23a or 28a-f show r must be notified at once. **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4014 21207 United 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner must be Never Married 2 Married White etc. Yes Black 4 Divorced Yes 2 No specify Widowed f Yes, Give Year is marked other than "natural", ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Department of Health and Mental Hygiene Inportant: If item 27 is marked other injury or other transment. Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) (1 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lakeah Tendleton - Daugher 3416 Garrison Blud Apti 3 Batto, MD 21215 20a. Method of Disposition 20b Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State crematory or other place) Metro Crematory Donation 5 Other Specify ign ture of Funeral Service Lice MD 21229 11651 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical End stave renal disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical g physician a X UNPENDED AMENDED #23a,27,perME,g863, 1/24/07 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the Live birth Ectopic pregnancy Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? Yes 2 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 V Yes Residence 6 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural within 24 hours after death To the Funeral Director: Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature 29c License number 29d Date signed (Month, Day, Year) O.C.M.E. November 28, 2006 Name and address of person who complet d cause of death (Item 23a) Assistant Medical Examiner Susan Hogan MD. 111 Penn Street, Baltimore, MD 21201 9 2006 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Elizabeth Odell Persky November 26,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore Co. If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 √F Yrs. Director 86 0 231-03**-**6747 Feb. 19,1920 Virginía Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location fshow 10d. Inside City Limits a or 28a-f show t be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a r than "natural", or items 23a the Medical Examiner must 3701 Old North Point Road 21222 by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Years <u>Seamstress</u> Sewing Industry injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental H Is marked William A. Lucado Fannie Fain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 Is Mr. Joseph Persky 104C Brookside Dr. Anna, Ohio Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 12/1/2006 Middle River, MD 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Delvis Due to (or s a consequence of): monta /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9∏Unknown 9 Unknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed' certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 24 hours after death. 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident neral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 266260 Hovenber 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. R. Ley G. & M. 6701 N. Charles St. Bolto. in 1 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

| State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2005 | | | | | | | | | | 37819 | | |
|--|--|--|---|--|-------------------------------|-----------------------|---|--|---------------------------------------|--------------------------------|--|--|
| | Dhysisi | | Decedent's Name (First, Midd | fle, Last) | | | | | 2. Date of Death | 1 | 3. Time of Death | |
| | Physici /Medi | | Dominica | | esgrav | ves | | | November | r | 1:23 a ^M | |
| | Examir | ner | 4a. Facility Name (If not institution Gilchrist Ce | | | | Tows | r Location of Death | | 4c. County of Dea | | |
| | Funeral | i i | 5. Social Security Number 212–20–3375 | | je (In yrs. la: B2 | st birthday) Yrs. | If Under 1 Year Months Days | | 8. Date of Birth (Month, Day, | 9. Bir | thplace (State or Foreign | |
| | Director | | Usual Residence of Decedent | | | 113. | | | uct. /, | 1724 Mai | Lyranu | |
| | arylan show d at | <u>_</u> | 10a. State 10b. Count | y Ltimore | | Town or Loc Towsor | | | | | 10d. Inside City Limits 1 ☐ Yes 2 No | |
| | the M | recto | 10e. Street and Number | rcinore | | rowsor | 10f. Zip Code | | 10 | g. Citizen of What Co | | |
| | 23a or ust be | ral Di | 109 Susquehanr | na Avenue | | | 21 28 | 6 | | U.S.A. | , | |
| 980 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 Ⅸ Divorce | If Yes, Give | | li li | Vas Decedent of H f Yes, specify Cuba ☐ Yes 2☐ No | ispanic Origin? (Sp an, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Ame Black, Whit | te, etc. | |
| 5-0 | 72 ho "natur edical | eted | 15. Decede (Specify only high | nt's Education est grade completed) | | 16a. Deced | ent's Usual Occup | ation during most of work f) | 16b. Kind of Business/Industry | | | |
| 21215-0036 | within giene. r than the Me | Completed | Elementary/Secondary (0-12) | College (1-4or 5 | 5+) | | oo not use retired nemaker | 1) | | Own ho | ome | |
| | be filed tal Hyg d other event, | Be | 17. Father's Name (First, Middle | | | | | | e (First, Middle, M | , | - | |
| Maryland | should id Men marke matic | ြို | Samue 1 19a. Informant's Name/Relation | | iano, | | n Address (Street | Rosa | al Route Number | Marina | | |
| | and 2 saulth ar 27 is er trau | | Davi d Presgra | | | | | h Rd. ,Lı | | | | |
| Baltimore, | iges 1 nt of He If Item or oth | 20a. Method of Disposition 20b. Place of Disposition (Name of Community) 20c. Place of Disposition (Name of Community | | | | | | | | 0c. Location - City or | | |
| ıltim | 4 Donation 5 M Other (Specify)Entombment Dulaney V | | | | | | | 11/30 ss of Facility Run | · | Timonium Funeral H | | |
| Ba | Depar Impo any ir | 1 1 | Mh | WIIIIdin | u. D | - 1 | | Rd., Tou | | | ione, inc. | |
| | | | 23a. Part1. Enter the disease, o shock, or heart failure. Lis | or complications that caused at only one cause on each li | g, such as cardiac | or respiratory arres | st, | Approximate Interval Between Onset and Death | | | | |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a. Due to (or as | a conseque | nce of): | MA | | | | menths | |
| | Examiner | | Sequentially list conditions. | b | | | | | | | | |
| | rted Insit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as | a conseque | nce of): | | | | | | |
| ,0 | icate be executed physician and s the burial-transit | Еха | that initiated events resulting in death) Last | cDue to (or as | a conseque | nce of): | | | | | | |
| 68760, | physic physic the be | edical | | d | | | | | | | | |
| P.O. Box (| The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown | 2 Fetal d | leath 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of del Month | ivery Day Year | |
| s, P | uires that the signed by detaction de detact | by Pt | Part II. Other significant condit | ions contributing to death b | ut not resulti | ing in the un | derlying cause give | en in Part I. | 23e. Did toba | acco use contribute to | | |
| Records, | w requir been si should I | | | | | | | | - | | obably 4 Unknown | |
| Rec | The law e has t age 2 s | Completed | 24a. Was an autopsy performed? | | | | | | | | utopsy findings available completion of cause of | |
| Vital | sician: The certificate har rector, page | BeC | 25. Was case referred to medica examiner? | al | 1 Yes 2 h (Check only one) | ∃No 1 □Yes | 2 No | | | | | |
| ō | Phys this ral dii | 은 , | 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence | | | | | | | | city) Hospice | |
| ion | Attending Phrades and death. ector: After this by the funeral. | Certification: | 1 ☐Natural 5 ☐ Pendi | | y Year) | Injury | | (? Yes 2 □ No | 200. Describe nov | injury occurred | | |
| Division | 그 후 후 ㄷ | rtific | 3 ☐ Sulcide 6 ☐ Could 4 ☐ Homicide determ | nined Zoe, Flace of IIII | ury - At hom c. (Specify) | e, farm, stre | et, factory, office | | 28f. Location (Stree City or Town, | eet and Number or Ru State) | ural Route Number, | |
| | To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the I | | 29a. Certifier 1 Certifyi | ng Physician: To the best | of my knowl | edge, death | occurred at the tin | ne, date and place, | and due to the cau | use(s) and manner as | s stated. | |
| | the Ho hin 24 I the Fu npletel | Medical | one) | I Examiner: On the basis of and manner sta | f examinatio ated. | n and/or inv | | | | | | |
| | To To | _ | 29b. Signature and title of certific | than las | e. | un | 29c. License | | | d. Date signed (Monti | | |
| | 15 | | 30. Name and address of persor | | | 3a) (Type, F | Print) | | 0 0. | . / - | 27,2006 | |
| 450 | | to | W. A. R. C. 31. Date filed (Month, Day, Year | ey GBMC | ar's Signatur |) / N | - Charl | es 17. 1. | salto. n | 14 212 | 2,0 | |
| -07 | State Registrar NOV 2, 9 2006 22. Registrar's Signature | | | | | | | | | | | |

1 - For State Registrar

Director

Completed by Funeral

To Be

Physician

/Medical

Examiner

Funeral

Director

| Ple | ase Type or Prir | nt in Black In | delible Ink | . Ensure A | II Copies A | re Legible | |
|---|--|--------------------------------------|--|-------------------------------|-----------------------------------|-----------------------------|--|
| _ For | State of Ma | aryland / Dep | | | 1ental Hygi | ene | |
| State Registrar | | Ce | rtificate of | Death | Reg | 9. No.2 A A | 27020 |
| 1. Decedent's Name (First, Mic | ldle, Last) | | | | Date of Death Month | Day Yea | 3. Time of Death |
| Margaret Ann | Piel | | | | | 26, 200 | |
| 4a. Facility Name (If not institut | ion, give street and number) | | 4b. City, Town, o | r Location of Death | | 4c. County of De | eath |
| | enter for Hosp | | Tows | | | Balti | |
| 5. Social Security Number 215–28–4230 | 6. Sex 7. Ag 1 ☐ M 2 🖾 F | e (In yrs. last birthday) 75 Yrs. | Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, 19) | (ear) 1930 M | irthplace (State or Foreign Country) aryland |
| Usual Residence of Decedent 10a. State 10b. Cour | ntv | 10c. City, Town or Lo | ocation | | | | 10d. Inside City Limits |
| . D 7. | _ | | | | | | 1 □Yes 2√⊋No |
| Har y Lana | imore | Catonsvi | Υ | | 10 | Citizen of Mhat (| |
| 10e. Street and Number 1453 N. Rolli | ng Road | | 10f. Zip Code 2122 | 28 | 10 | g. Citizen of What (USA | Jountry? |
| 11. Marital Status | 12. Was Decedent | Ever in U.S. 13. | Was Decedent of H | lispanic Origin? (Sp | ecify Yes or No- | | nerican Indian, |
| 1 Never Married 2 X M | Armed Forces? | | If Yes, specify Cub | an, Mexican, Puerto | Rican, etc.) | Black, Wi | |
| 3 ☐ Widowed 4 ☐ Divord | If Yes. Give | | 1 ☐ Yes 2 ☑ No | Specify: | | Specify: W | nite |
| | ent's Education hest grade completed) | 16a. Dece | edent's Usual Occup | oation during most of work | ing 1 | 6b. Kind of Busines | s/Industry |
| Elementary/Secondary (0-12 | | life. | DO NOT use retire | d) | "'y | | |
| , | 5+ | | eacher | | | Educ | cation |
| 17. Father's Name (First, Midd | le, Last) | | | 18. Mother's Name | e (First, Middle, M. | aiden Surname) | |
| William Palme | r Spicer | | | Mary | Herbert | | |
| 19a. Informant's Name/Relation | nship (Type. Print) | 19b. Maili | ing Address (Street | and Number or Rui | al Route Number, | City or Town, State | , Zip Code) |
| Richard Piel | Husband | 1453 | N. Rolli | ne Road. | Catonsvi | lle Mars | 71and 21228 |
| 20a. Method of Disposition | | 20b. Place of Disp | osition (Name of ematory or other pla | i | Date 2 | Oc. Location - City | or Town, State |
| 1 ☑ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other | n 3 □Removal from State (Specify) | 1 | | ery 12/2/ | '2006 Ba | ltimore, | Maryland |
| 21. Signature of Euneral Servi | | | | | | | vab Witzke |
| 1/ lun | 1 // | | Funeral F | lome of Ca | tonsvill | e, Iņç, | _MD 21228 |
| 23a. Part1. Enter the disease | of complications that caused | | | | | | Approximate |
| shock, or heart failure. L | ist only one cause on each li | ne. | | • | | | Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) | _a | | tic Br | east (| Mucel | | year |
| resulting in death) | Due to (or as | a consequence of): | | | | | 0 |
| Sequentially list conditions. | b | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as | a consequence of): | | | | | |
| that initiated events resulting in death) Last | с | | | | | | |
| resulting in death) Last | Due to (or as | a consequence of): | | | | | |
| | d | | | | | | |
| IF FEMALE: | | | | | | | |
| 23b. Was decedent pregnant | 23c. If yes, outcome | | □Ectopic pregnanc | v | | 23d. Date of d | |
| in the past 12 months? 1 ☐ Yes 2 ☐ No | 4□Pregnant at | | Other (specify) | | | Month | Day Year |
| 9 ☐ Unknown | 9□Unknown | | | | | | |
| Part II. Other significant cond | litions contributing to death b | ut not resulting in the u | underlying cause giv | en in Part I. | 23e. Did toba | acco use contribute | to the cause of death? |
| | | | | | 1 ☐ Yes | 2 No 3□ | Probably 4 Unknown |
| 96 | | | | _ | 24a. Was an | 24h Were | autopsy findings available |
| | | | | | autopsy | l prior to | o completion of cause of |
| | | | | | 1∐ Yes 2 | No 1 □Ye | |
| 25. Was case referred to med examiner? | | | 100 | | h (Check only one, | | |
| 1 ☐ Yes 2 ☑ No | Hospital: 1 Inpatie | ent 2 ER/Outpatie | nt 3 DOA | ner: 4 Nursing Ho | ome 5 Residen | ce 6 Bother (Sp | pecify) + 0 > 0 1 CQ |

Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Physician/Medical ate has been signed by the attendin page 2 should be detached for use Be Completed by neral Director: After this certific filled in by the funeral director, Certification: To Medical

/Medical Examiner

> in the past 9 Unkno Part II. Other sig 25. Was case re examiner? 1 ☐ Yes 2 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury at Work? Injury 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie November 27, 2006

State

Registrar

W. A. Riley

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of leath (Item 23a) (Type, Print)

6701 82. Registrar's Signature

6-BMC

N. Chales St.

Baltz. md 2:204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day William Edward Ruhleman Month Year NOVEMBER 27, 2006 Ø1:15A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 **X**M 2 □ F Months Days Hours Min. 215-14-0301 83 July 11,192B Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Baltimore Co. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2700 Linwood Ave. 21234 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. 1. Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 08 College (1-4or 5+) n/a Postal Clerk U.S. Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Ruhleman Ernestine D. Dix 19a. Informant's Name/Relationship (Type. Print) (Dau. In 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Law) 4642 Riddle Drive Baltimore, MD. 21236 <u>Stephanie A. Maddox</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Parkwood Cem. Nov.30,2006 4 Donation 5X Other (Specify)Entombment Baltimore, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chapel&Cremation Services Rd. Parkville,MD.21234 D Evans Funeral 8800 Harford Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CONGESTIVE HEART FAILURE 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy 2 No 1 ☐ Yes 2 No 1□ Yes 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Examiner

Physician/Medical

2

Be Completed

Certification: To

Medical

Physician

/Medical

Examiner

MD

Funeral

Director

show

"natural", or items 23a or 28a-f shov edical Examiner must be notified at

the Medical

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; if item 27 is marked other than 'any Injury or other traumatic event, the Mean once.

Funeral

≥

Completed

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed and burial-trar Division or Vital Records, P.O, Box 68760, physician the as attending use for ed by the a signed by page 2 should certificate has director. this

funeral c

Physician: After Hospital or Attending death. within 24 hours after death To the Funeral Director: filled in by the completely

State

To the

25. Was case referred to medical examiner? examiner? 28b. Time of 27. Manner of Death Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident (Month. Day Year) 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11 06

D37254

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Pegistrar's Signature DRIVE TOWSON, MARYLAND 21204

Registrar

| | | | For | | State of | Maryland | - | artment | | | and Me | | | 2 n n s | | 272 | 22 |
|----------------------------|---|---------------------|--|---------------------------------|--------------------------------------|--------------------------------|------------------------|---|-----------------------|--------------|--|--------------------------------|--|---------------------------|----------------|---------------------------------------|---------------|
| | | | State Registrar 1. Decedent's Name (Firs | t Middle Las | *) | | Cei | uncate | OIL | eatn | | 2. Date of De | Reg. Not ath | 2000 | 0 | 3. Time of D | Death |
| п | Physici | | Mary Cathe | | | iger | | | | | | Novem) | | 27, 20 | | 2:0 | |
| | /Medic Examin | | 4a. Facility Name (If not in | stitution, give | street and num | nber) | | 4b. City, | Town, or I | Location o | of Death | | 4c. County of Death | | | | |
| | | | 8401 Kavar | agh R | oad | | | Bá | alti | more | <u> </u> | | Baltimore Co. | | | | |
| | Funeral | | 5. Social Security Number | | x □M 2120F | 7. Age (In yrs. la | | If Under Months | 1 Year Days | If Under : | 24 Hrs. Min. | 8. Date of Bir (Month, Da | orth Jay, Year) 9. Birthplace (State or Foreign Country) 9. Baltimore MD | | | | |
| | Director | | 213-01-506 | 4 | | 99 | Yrs. | | | | | Aug.0 | 1,19 | 907 B | alt | imor | a, MD |
| | and w | | Usual Residence of Dece- 10a. State 10b. | County | | 10c. City | , Town or Lo | cation | | | | | | | 10d | . Inside City | Limits |
| | Maryl f sho | ō | MD Ba | ltimo | re Co. | Bal | timo | re | | | | | | 1 ☐ Yes 2 🕍 No | | | 2 - No |
| | the notifie | rec | 10e. Street and Number | | | | | 10f. Zip | Code | | | | 10g. Citi | zen of What | Country | 1? | |
| | h with | Ö | 8401 Kavan | agh R | oad | | | | 21 | 222 | | | Uni | ted S | Stat | ces | |
| | deatl | ner | 11. Marital Status | | | dent Ever in U.S | 3. 13. | Was Deced | ent of His | panic Orig | gin? (Spec | cify Yes or No Rican, etc.) | - | 14. Race - Ar Black, W | | | |
| 9 | within 72 hours after death with the Maryland ene. than "natural", or itema 23e or 28e-f ehow than "medical Examinar must be notified at | by Funeral Director | 1 Never Married 2 | | 1 ☐ Yes If Yes, Give | 2 ☐ N io | | 1 ☐ Yes 2 | | | ,, | | | Specify: | | ite | |
| 8 | ural!, | d b | 3 ☐ Widowed 4X D | | Year or Da | ites: | | | | | | | | | | | |
| 75 | n 72 "nat | ete | (Specify onl | | de completed) | | (Give | ient's Usua kind of wor DO NOT us | k done di | ırina most | t of workin | g | 100. KII | nd of Busines | SSAITIGUS | stry | |
| 21215-0036 | iene. | Completed | Elementary/Secondary 06 | (0-12) | College (1- n/a | -4or 5+) | Н | ome M | lake: | r | | | | Own I | Hom | е | |
| פַ | e filed Il Hygi other | Bec | 17. Father's Name (First, | Middle, Last) | | | | | | 18. Mothe | r's Name | (First, Middle, | Maiden | Surname) | | | |
| Maryland | Mental Mental arked c | ToE | Cesare Vil | la | | | | | | Rosa | Pog | ggioli | - | | | | |
| lan. | 2 sho and le ma | | 19a. Informant's Name/R | | | | | - | | | | Route Number | | | | | |
| | end lealth m 27 | , | Stephen A. | | inger(| | | re C | | | | ille, | | Land | | 1234 | |
| 101 | Pages 1 nent of H int: If ite iry or ot | | 20a. Method of Disposition 1 ☐ Surial 2 ☐ Crer | mation 3 🔲 | | state | metery, crer | | | 1 | Dec. | .01, | | • | | | |
| Baltimore, | | | 4 Donation 5 0 | | | HOT | y Rec | | | | 200 | | Balt | imor | e,M | aryla | and |
| Ba | permit. Departr Imports any inji | | > Jeffre | in Li | , yav | e, Dr. | E 8 | vans 800 | Fur Harf | era ord | l Ch Rd. | apel& Par | Crem kvi] | nation Lle,M | n So | ervio 1234 | ces |
| | | | 23a. Party Enter the dise shock, or heart failu | ese, or comp re. List only o | lications that ca one cause on ea | aused the death ach line. | . Do not ent | er the mode | e of dying, | , such as | cardiac or | respiratory a | rrest, | | - A | pproximate terval Betwonset and De | een |
| | Physician | | Immediate Cause (Final disease or condition | | a | Cardiac | arr | est/ | ven | itri | cula | r arr | hyth | mia | | econo | |
| | /Medical Examiner | | resulting in death) | | | or as a consequ | | ٠ د | | | | | | | | | |
| Н | | ٥ | Sequentially list condition if any, leading to immedia | is, | D | Myocaro | | inia | rcti | .on_ | | | | | m: | inute | }S |
| | ansit (A) | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | ~ | . 7 | Atheros | scler | otic | car | dio | vasc | ular o | dise | ase | V | ears | |
| ó | ificate be executed Thysiclen and as the burial-transit | | resulting in death) Last | - 1 | | or as a consequ | | | | | | | | | | | |
| 3760, | ate be nysicl he bu | Icai | | • | d | | | | | | | | | | | | |
| 68 | artifici | Med | IF FEMALE: | | | | | | | | | | | | 1 | | |
| Вох | death certifica e attending ph d for use as th | lan/ | 23b. Was decedent pregr in the past 12 month | iant | 1☐Live bi | come of pregnar rth 2 Fetal | death 3 | Ectopic pre | | | | | 2 | 3d. Date of on Month | delivery Da | ay Ye | ear |
| P.0. | res thet the death certificate igned by the attending phys be detached for use as the | Physician/Med | 1 ☐ Yes 2∕DNo 9 ☐ Unknown | | 4∐Pregna 9∐Unkno | ant at time of de wn | ath 5L | Other (spe | ecity) | | | | | | | • | |
| ٦. | thet the ded by detac | F. | Part II. Dther significant | conditions co | entributing to de | ath but not resu | Iting in the u | nderlying ca | ause giver | n in Part I. | | 23e. Did t | obacco u | se contribute | to the | cause of de | ath? |
| gp. | uires Id be | d by | End st | tage A | lzheim | mer's I | Disea | se | | | | 10 | Yes 2 <mark>X</mark> | ∭ o 3 □ | Probab | ly 4 □Ur | nknown |
| S | s been s should | jete | Advanc | ced ac | re | | | | | | | 24a. Was | | 24b. Were | autopsy | y findings av | vailable |
| Division of Vital Records, | The law requires thet set to set to the set to set | Completed | | | | | | | | | | autor perfo | rmed? | death | es 2 | letion of cau □ No | 120 01 |
| ital | | Be C | 25. Was case referred to examiner? | medical | | | | | | | of Death | (Check only o | | | | | |
| <u>></u> | Physician: this certifical | ှ | 1 ☐ Yes 2 No | | | patient 2 E | | | | 401140 | | e 5 Resi | | | pecify) | | |
| ū | | ë E | 27. Manner of Death 1 Natural 5 | Pending | 28a. Date o (Month | nt Injury h, Day Year) | 28b. Time of Injury | | Bc. Injury a Work? | | | 8d. Describe I | now injury | y occurred | | | |
| sio | Attending r death. sctor: Alter | cat | 2 Accident 3 Suicide 6 | investigation [Could not be | n/a | of Injury - At hor | ma form sta | M | | es 2 🗆 i | | n/a 8f. Location (| | Alumboror | Pumi G | Pouta Mumb | 10.6 |
| <u></u> | # # # # # # # # # # # # # # # # # # # | ertification: | 4 Homicide | determined | buildin | ig, etc. (Specify |) | еві, іасіоту | , onice | | | City or To | | | riulairi | IODIO POIND | 67, |
| _ | To the Hospital or Attentwithin 24 hours effer death To the Funerel Director: completely filled in by the | ပ | 29a. Cepitier 1 | Certifying Phy | /sician: To the | best of my know | vledge, deati | occurred a | at the time | e, date an | d place, a | n/a nd due to the | cause(s) | and manner | as state | ed. | |
| | HO: 124 h | edical | (Check only 2 1 | ledical Exem | iner: On the ba and mann | sis of examinati | ion and/or in | vestigation, | in my opi | nion, deat | th occurre | d at the time, | date and | place, and d | ue to th | e cause(s) | |
| | To th To th Comp | Me | 29b. Signature and title of | Certific | A | n n | 1/ | 29c | . License | | | | | signed (Mo | | y, Year) | |
| | í | | // hust | V V | oxer / | 1/// | 1 | | MD | D253 | 332 | | 11/ | 28/06 |) | | |
| | N | | 30. Name and address of Milford N | person who | completed cause | 1 | | | | | | | | | | | |
| | \ | | | | | | 9 W. | redv | poor | St | Bal | ltimor | e,M | D 212 | 01 | | |
| | Sta Registr | ite ar | 31. Date filed (Month, Da | 2 9 200 | 6 | ide M | ha | N. 6 | | | | | | | | | |
| DH | IMH 17 Rev 1/2 | 001 | | | 1 | , J.J. | 1 | The sales | | | | | | | | | |

| | | | For State | State of | of Marylan | | artment of | | | | giene 0 | 06 | 37823 |
|----------------------------|--|----------------|---|--|----------------------------------|------------------------------|---|--------------------------|---------------|-------------------|-------------------|-----------------------|--|
| | | | Registrar 1. Decedent's Name (First, Middle, | Last) | | | | | | 2. Date of Dea | | | 3. Time of Death |
| | Physicia | an | Richan | | Reglan | 0 | | | | Month Joven | Day 77 | Year 200(| 12:55 |
| | /Medic | | 4a. Facility Name (If not institution, | | | | 4b. City, Town | or Location | | 00 JEWI | | y of Death | 12.00 |
| | Examin | er | 1 | ng Bayu | • | -1 (00) | | altr | • | P | | N/A | |
| | Comment | | | 6. Sex | 7. Age (In yrs. | | If Under 1 Yea | r If Under | 24 Hrs. | B. Date of Birt | | | place (State or Foreign |
| | Funeral Director | | 212 42 5392 | 1ÅM 2□F | 62 | Yrs. | Months Day | s Hours | Min. | March 8 | , 1944 | Mar | vIand |
| | | | Usual Residence of Decedent | | | | | | | | | 1 | |
| | yland | | 10a. State 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | | 1 | 10d. Inside City Limits |
| | Mar Mar | to | Maryland N/A | | I | 3altimo | ore | | | | | | 1 X Yes 2 ☐ No |
| 10 | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | Directo | 10e. Street and Number | | | | 10f. Zip Code | | | | 10g. Citizen of | What Cour | ntry? |
| | death with the Maryland rms 23a or 28a-f show rmust be notified at | O C | 1101 St. Pau | 1 Street | | | 2 | 1202 | | | U.S | • | |
| | deat deat | Funeral | 11. Marital Status | 12. Was Dec | cedent Ever in U | .S. 13. | Was Decedent of | Hispanic Or | igin? (Spec | rly Yes or No- | 14. Ra | ce - Americ | |
| ٥ | or its | F | 1 X Never Married 2 ☐ Marrie | | 2 🗆 No | | 1 ⊡Yes 2.50 N | | | ican, etc.) | | y: Whi | |
| 15-0036 | hours after tural', or its al Examina | 1 by | 3 Widowed 4 Divorced | Year or I | | | 10 103 2401 | o opocny. | | | Зрест | y. WIII | |
| ה | 72 h netu | Completed | 15. Decedent's (Specify only highest | |) | 16a. Deced | dent's Usual Occ kind of work dor DO NOT use reti | upation le during mos | at of working | g | 16b. Kind of 8 | 3usiness/In | dustry |
| 7 | 19 9 19 19 19 19 19 19 19 19 19 19 19 19 | du | Elementary/Secondary (0-12) | College | (1-4or 5+) | | DO NOT use reti Bus Dr | | | | Bus Co | mnonsi | |
| 7 | tiled within 72 Hygiene. sther than "natent, the Medici | ဝိ | 12th | | | 1001 | Dus Di | | | (F) | | | |
| בַ | 0 4 5 5 5 | Be | 17. Father's Name (First, Middle, L | nard C. | Doolond | | | | | he Glas | Maiden Suma SS | me) | |
| <u>₹</u> | 2 should be and Mental is marked o | မ | | | Nagianu | | | | | | | | |
| _ | es 1 and 2 should to of Health and Ment I Item 27 is marked r other treumatic e | İ | 19a. Informant's Name/Relationsh Robert W. Lay | | | | ng Address <i>(Str</i> e St. Pau | | | | | | |
| _ | 1 and Health em 27 ther to | | | / FITEII | 20h F | | sition (Name of | I DLIC | Da Da | | 20c. Location | | |
| 5 | Pages 1 nent of H int: if ite iry or ot | | 20a. Method of Disposition 1 ☐ Burial 2 X Cremation | 3 Removal from | State | semetery, crer | natory or other p | | | | | | |
| 틀 | | | 4 Donation 5 Other (Sp | | Ва | - | Cremator | | 11/29 | | | | Maryland |
| Baltimore, | permit. Depertr Import | | 21. Signature of une al Service L | icensee) | 1 | 1.75 | 2. Name and Add | | | | ieral S | | * |
| | 00 = 0 a | | reno | wan | way | | | | | | | Mary. | 1and 21225 |
| | | | 23a. Part1. Enter the disease, or o shock, or heart failure. List of | omplications that inly one cause on | | | | | | | rest, | | Approximate Intervat Between Onset and Death |
| , F | Physician | | Immediate Cause (Final disease or condition | 10 | trace | reb. | al H | emm | 10-h | 440 | | 1 | 36 hours |
| | /Medical Examiner | | resulting in death) | Due to | (or as a conseq | juence of): | | | | 7- | | | |
| | Examine | , | Sequentially list conditions. | b | | | | | | | | | |
| | ii g | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to | (or as a conseq | juence of): | | | | | | | |
| | and and tran | Саш | that initiated events resulting in death) Last | c | (or as a conseq | wanaa al\: | | | | | | | |
| 9 | ate be executed thysicien and the buriat-transit | | , | Due 10 | (01 83 8 0011360 | juence or). | | | | | | | |
| 8760 | icate be executed physicien and s the buriat-transit | dicai | 2. | d | | | | | | | | | |
| 9 X | death certific e ettending p nd for use as | Physician/Me | IF FEMALE: | 23c If yes or | utcome of pregna | ancy | | | | | 2010 | -11-1-1 | |
| Вох | ath c etten otten | lan | 23b. Was decedent pregnant in the past 12 months? | 1 Live | birth 2 Feta | ıldeath 3 [| Ectopic pregnar | | | | | ate of delive onth | ery Day Year |
| | | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□ Unkr | | Math 5 | Other (specify) | | | | | | |
| <u>a</u> . | res that the de igned by the e be detached f | | Part II. Other significant condition | as contributing to | death but not res | ulting in the u | ndertving cause | given in Part I | l. | 23e. Did to | obacco use cor | ntribute to the | he cause of death? |
| Division of Vital Records, | The law requires that the tee has been signed by thosage 2 should be detached. | Completed by | Circhosis | • | | | , , | | | 101 | res 2□No | 3 Prob | pably 4 Unknown |
| Ö | w requir been si should | ete | <u> </u> | | | | | | | 04- 116- | 045 | 144 | in the second second |
| ě | elaw hasl je2s | mpi | | | | | | | | 24a. Was autop | an 246. rmed? | prior to co death? | opsy findings available impletion of cause of |
| ä | | | | | | | | | | 1□ Yes | 2 No | 1 ☐ Yes | 2□ No |
| \frac{1}{5} | icier certif recto | Be | 25. Was case referred to medical examiner? | Hospital: | / | | | Whor | | (Check only o | | | |
| 5 | Attending Physicien: It death. Sector: After this certifica by the funeral director. | : To | 1 ☐ Yes 2 ② No 27. Manner ol Death | 15 | | ER/Outpatier 28b. Time of | IL SLI DON | 4 🗆 141 | | | dence 6 Ot | | (y) |
| 5 | ding f h. After funer | tion | 1 Natural 5 ☐ Pending | | of Injury oth, Day Year) | Injury | V | ork? □Yes 2□ | | 5d. 50001100 I | ion anjuly cool | 1100 | |
| S | or Attencafter death Director: In by the | lica | 3 ☐ Suicide 6 ☐ Could n | ot be 380 Plac | e of Injury - At h | ome, farm, str | | | | BI. Location (S | Street and Num | ber or Run | al Route Number, |
| _ | 5 5 5 ⊆ | Certification; | 4 ☐ Homicide determin | build | ling, etc. (Specia | (y) | 7, | | | City or Ton | vn, State) | | |
| _ | spita tours nerai fillec | | 29a. Certifier 1 Certifying | Physician: To th | e best of my kno | owledge, deat | h occurred at the | time, date ar | nd place, as | nd due to the | cause(s) and m | ianner as s | stated. |
| | E Fulletely | Medical | (Check only 2 Medical E | xaminer: On the l | basis of examina nner stated. | ation and/or in | vestigation, in m | y opinion, dea | ath occurre | d at the time, o | date and place | , and due to | o the cause(s) |
| | To the Hospital within 24 hours a To the Funeral Completely filled | Me | 29b. Signature and title of confifier | \ | | | 29c. Lice | nse number | | | 29d. Date sign | ed (Month, | Day, Year) |
| | | |) - Junt + | toha | | | RE | 5-0 | 000 | | Journal | eer 7 | 7 2006 |
| | nxl | | 30. Name and address of person v | vho completed cau | ise of death (Iter | n 23a) (Type. | Print) | | | 10 | | | -, 2006 |
| | 12 | | Dr. Justin | Turn | er | 1940 | Easte | m A | Jenu | e Ba | altino | 10.1 | MD 2122 |
| | Sta | te | 31. Date liled (Month, Day, Year) | | ngistrar's Signa | ature | all D | | 20% | | | | |
| 5 | Registr | ar | MAY 2 C | 2006 8 | BELLEN . | A M | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 16 1- State Amend item#31, perDVR, g861, 11/29/06 Tertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Evanne Robinson November 20, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3448 Marble Arch Drive Pasadena
If Under 1 Year If Under 24 Hrs. Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10M XDE Days Hours Yrs. Director 62 212-48-3676 Usual Residence of Decedent 1944 Virginia the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits "naturel", or iteme 23a or 28a-f ehov olical Examiner must be notified at 1 Yes X No Directo MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3448 Marble Arch Drive 21122 United States ould be filed within 72 hours after death Mental Hygiene. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) f other than " Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Dance Studio 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roland Robinson ပ Hattie M. Fogg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Joyce Benson - Sister-in-law 414 First Ave., Lansdowne, MD 21227 20a Method of Disposition 20% Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite eny injury or ot once. Rest Arundel 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-27-2006 4 □ Conation 5 □ Other (Specify) Odenton, MD Grematery Ambrose Funeral Home, Inc. 21. Signature of Fur eral Service I sense-7 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Arterio Scherotiz Condid Varanda Hypertensive
Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificete has b lirector, page 2 s 24a. Was an 1 ☐ Yes 2 2 No of Vital To the Hospitel or Attending Physician: Director: Alter this certific in by the funeral director, 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 3 DOA 27. Mann- I Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred **Division** 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funerel Di completely lilled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address masson who completed cause of death (Item 23a) (Type, Print) Christopher
31. Date filed (Manth, Day, Year) Pasadena MD 21122 3708 deBorn 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Division or Vital Records, P.O. Box 68760, within 24 hou To the Fune completely fi

6 State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) NOV 2 9 2006

30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print)



D40371

11/27/06

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 9 2006

32. Registrar's Signature

| | | ı | 1 - For State Registrar | State of | Marylar | nd / Depa <i>Cei</i> | artment of Hartificate of | Health an <i>Death</i> | nd Mental Hy | giene 006 | 37827 |
|------------------|--|---------------------|--|---|--------------------------------|-----------------------------------|---|---|---|--|--|
| | Dhysiai | 20 | 1. Decedent's Name (First, Middle, | Last) | | | | | 2. Date of De | eath | 3. Time of Death |
| | Physici /Medic | | Helen Glover Ra | | | | | | Novembe | | 06 3:45 PM |
|) | Examin | er | 4a. Facility Name (If not institution, Glen Meadows | give street and num | nber) | | 4b. City, Town, o | | Death | 4c. County of D Balti | |
| | Funeral | | · | 6. Sex 1 ☐ M 2 💢 F | 7. Age (In yrs. | | If Under 1 Year Months Days | | Min. (Month, Da | ay, Year) | Birthplace (State or Foreign Country) |
| | Director | | 212-60-1261 Usual Residence of Decedent | | 9 | 6 Yrs. | | | January | 73,1910 | Maryland |
| | yland | | 10a. State 10b. County | | 10c. Ci | ty, Town or Lo | cation | | | | 10d. Inside City Limits |
| | e-fet | ctor | Maryland Baltin | nore | G | len Ar | m | | | | 1 ☐ Yes 2 No |
| | or 28 | Dire | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen of What | • |
| | ath w | rail | 11630 Glen Arm I | | | | 21057 | | | United St | ates |
| 36 | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If the Maryland 27 le marked of ther than "naturel; or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at | by Funeral Director | 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced | 12. Was Decer Armed For 1 Tes If Yes, Give Year or Da | ces? 2 ∭ No ∋ | 1 | Vas Decedent of H fYes, specify Cub I□Yes 2X No | lispanic Origin an, Mexican, P Specify: | ? (Specify Yes or No Puerto Rican, etc.) | Black, W | merican Indian, hite, etc. white |
| Ö | 72 hou | ted | 15. Decedent | | | 16a. Deced | lent's Usual Occup | pation | | 16b. Kind of Busine | |
| 2 | ithin 7 | Completed | (Specify only highest Elementary/Secondary (0-12) | College (1- | 4or 5+) | life. L | kind of work done OO NOT use retire | during most of d) | t working | | |
| 2 | led wi ygien her th | Con | | 1 | | home | maker | - | | own home | |
| | id be fil ental H ked oti ic even | To Be | 17. Father's Name (First, Middle, L Harry Clay Glove | • | | | | | Name (First, Middle che Ironmo | | |
| ary | should and Men marke | | 19a. Informant's Name/Relationsh | ip (Type, Print) | | 19b. Mailin | g Address (Street | | | er, City or Town, State | a, Zip Code) |
| | 1 and 2 Health a tem 27 le | | Diana H. Johnson | n/cousin | | | Creek Ro | d. Ki | tty Hawk, | NC 27949 | |
| ore | Pages 1 nent of Hi ant: If Iter ary or oth | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation | 3 □Removal from S | | Place of Dispos semetery, cren | sition (Name of natory or other plan | ce) | Date | 20c. Location - City | or Town, State |
| altimore, | t. Pa | | 4 Donation 5 Other (Sp. | ecify) | | | | | v. 29,2006 | | n, Maryland |
| Ba | permit. Pages Depertment of Important: If It any Injury or o | | 21. Signature of Funeral Service L | tchell | | | 0000 | YORK KO | ı. Baltı | neral Home more, MD | Inc. 21212 |
| | | | 23a. Part. Enter the disease, or c shock, or heart failure. List of | inty one cause on ea | ch line. | | | ng, such as car | rdiac or respiratory a | rrest, | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a | ROSCL | | 5 | | | | yeard |
| | Examiner | | | Due to (d | or as a conseq | uence of): | | | | | 1 |
| ļ | | Jer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. — Due to (c | rasa conseq | uence of): | - | | | | |
| V | cate be executed physicien and the burial-transit | Examin | that initiated events | с | | | | | | | |
| Ö, | oe exe | | resulting in death) Last | Due to (d | r as a conseq | uence of); | | | | | |
| 8760, | 을 본 = | dicai | | d | | | | | | | |
| 9 X | eath certifications attending properties as | Physician/Me | IF FEMALE: | 23c. If yes, outc | ome of preana | incv | | | | 024 Date - 6 | (-t) |
| P.O. Box | death e atter d for u | iciar | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No | 1 Live bir | th 2 □ Feta nt at time of d | I death 3 🗌 | Ectopic pregnancy Other (specify) | ' | | 23d. Date of o | Day Year |
| O. | at the de by the a | hys | 9 🗌 Unknown | 9□ Unknov | | | | | | | |
| Vital Records, F | gne gne be d | 6 | Part II. Other significant condition | s contributing to dea | ath but not res | ulting in the un | derlying cause giv | en in Part I. | | 1/ | to the cause of death? Probably 4 Unknown |
| ဝ၁ | law re | Completed | | | | | | | 24a. Was | | autopsy findings available |
| <u> </u> | The ete h page | E OC | | | | | | | autop perfo 1 ☐ Yes | rmed? death | o completion of cause of ? es 2 No |
| <u> </u> | ertifi | Be | 25. Was case referred to medical examiner? | Has-ital. | | | | | Death (Check only o | | |
| 0 | Phys this aldi | 2 | 1 ☐ Yes 2 ☐ No 27. Manner of Death | | | ER/Outpatient 28b. Time of | | 4 LF Nursin | | dence 6 Other (Sp | pecify) |
| 5 | ding h. After fune | tion | 1 Natural 5 Pending 2 Accident investiga | | , Day Year) | Injury | 28c. Injur Wor M 1 | yat k? Yes 2∐No | 28d. Describe i | low injury occurred | |
| /ISI | Attending r death. ector: After by the fune | ifica | 3 ☐ Suicide 6 ☐ Could no | ot be 28e. Place of | of Injury - At ho | ome, farm, stre | et, factory, office | | 28f. Location (5 | Street and Number or | Rural Route Number. |
| | s afte st Dire | Certification: | 4 Homicide | building | g, etc. (<i>Specif</i>) | () | | | City or Tov | vn, State) | |
| | To the Hospital or Attending in within 24 hours after death. To the Funerel Director: After completely filled in by the funer | edical | 29a. Certifier 1 Certifying (Check only one) 2 Medicaf E | Physician: To the base xaminer: On the base and manner | sis or examina | wledge, death tion and/or inv | occurred at the tinestigation, in my o | ne, date and pi pinion, death o | lace, and due to the occurred at the time, | cause(s) and manner date and place, and d | as stated. ue to the cause(s) |
| | To th To th comp | Me | 29b. Signature and title of certifier | / | | ··· | 29c. Licens | | | 29d. Date signed (Mo | |
| | | | > mada | lyns | | | 03 | 0433 | 5 | Nor 22, | 2006 |
| | O | | 30. Name and address of person w | ho completed cause | of death (Item | 23a) (Type, F | Print) MARU | S. J. | T RAIT | PIMBRIC | MD 21204 |
| | Sta | | 31. Date filed (Month, Day, Year) | 32. Re | gistrar's Signa | | | | | | |
| | Registra | ar | NOV 2. 9. 2008 | Beaut | 13. | G0042 | | | | | |

Division or Vital Records, P.O. Box 68760.

3altimore, Maryland 21215-0036

within 24 hours To the Funeral Medical 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MINI 31. Date filed (Month, Day, State Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Marry Kenneth Saia 11-28-2006 0530 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie 1208 Cedarcliff Drive Anne Arundel 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 1**X** M 2□ F 65 **Director** 219-40-8826 11/10/1941 Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Anne Arundel 1 ☐ Yes 2√ No Director Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1208 Cedarcliff Drive Funeral 21060 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2√2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Reliable Contracting Elementary/Secondary (0-12) College (1-4or 5+) 11 Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame) Be Salvatore Saia ဥ Anna Fearheart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda R. Saia / Wife 1208 Cedarcliff Drive, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arundel Crematory 12/03/2006 Odenton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rendon-Bailey Funeral Home, P.A. M01452 E. BALTIMORE 2818 ST, BALTIMOTE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE HEART FAILURE YEAK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 1 Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 2 1 Inpatient 2 ER/Outpatient 3□ DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) homes walses MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Farm ROAD ARNOLD MD 21012 277 Peninsula

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ([] [] 5 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:53 AM 26,2006 Joseph Andrew Sudia, Ph.D November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Joseph Medical Ctr.
5. Social Security Number 6. Sex 7. Ag Towson
If Under 1 Year | If Under 24 Hrs. Baltimore County Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**∑**1 M 2 □ F Months Days Hours Yrs. Director 220-52-6697 54 Oct.14,1952 Austin,Texas Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore Co. Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8300 Bon Air Road 21234 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 25 Married 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced 27 is marked other than "natur traumatic event, the Medical Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Professor of Finance and Marketing College (1-4or 5+) Education 08 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew Thomas Sudia Mary Eileen Tenhaeff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health a importent: if item 27 is any injury or other train once. Cynthia Louise Sudia(wife) 8300 Bon Air Road Parkville, MD. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Nov. 27, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) 2006 Timonium, MD. 22. Name and Address of Facility
Evans Funeral Chapel&Cremation Services
8800 Harford Road Parkville, MD. 21234 21. Signature of Funeral Service Licenses Enter the dispesse, or complications that caused the death. k, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovascular Disesse **Physician** Artenioscleratic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The taw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certiticate has birector, page 2 s autopsy performed? Yes 2 No 1 🗌 Yes 1 Yes 2 No Hospital or Attanding Physician: After this certification, funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident within 24 hours etter death To the Funeral Director: , completely filled in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

31. Date filed (Month, Day, Year) State NOV 2 9 2006 Registrar

29b. Signature and little of certifier

32. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Trimble HillCT. Lutherville, MD 21093

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records,

2006 753AM

29c. License number

1866

06-07759 James Stricker

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

| 2006 378 | 3 | |
|----------|---|--|
|----------|---|--|

| | | For State | | | | Certifica | ate of | Death | | | | F | Reg N | o. 2 U | | | 001 |
|--|------------------|---|-----------------------|------------------------------|-----------------------|----------------|--------------------|----------------------|---------------|----------------------|------------|------------------------|--------------|----------------------------|---------------------|---------------------------------|---------------|
| Physician | | egistrar . Decedent's Name (First, | /liddle,La | st) | | | | | | | 2 | 2. Date of De Month | ath Day | v Year | | 3. Time of De | |
| ledical Examine | | James Richard | Str | icker | | | | | | | | October | 16, 2 | 006 | | 0401 hrs | 3 |
| | 4 | a. Facility Name (if not ins | itution, gi | ive street and n | umber) | | 41 | b. City, Tov | | ocation of | Death | | | 4c. County of Baltimore | | .4., | 1 |
| | | St. Joseph Medica | I Cente | er | | | | Towsor | | | | | | | | • | |
| Funeral | 5 | . Social Security Number | 6. 8 | Sex | 7. Age (Ir | yrs. last birt | hday) | If Under | Year | If Under Hours | 24Hrs. | 8. Date of B | Birth (M | M/DD/YYYY) | 9. Birth Foreign | iplace (State 1 Ra 1 + i i | nore. |
| Director | 12 | 212-48-9958 | 1 | XM 2 F | | 59 | Yrs. | MOUNT | Days | Hours | IVIII | Dec.0 | 5,1 | 946 | Cou | Balti Mary | land |
| | ι | Jsual Residence of Deced | nt | | | | | | | | | | | | | 10d Inside C | |
| any | 1 | 0a. State 10b. Co | unty | | 100 | c. City, Town | or Location | on | | | | | | | | 1 Yes | |
| show ed | = _N | Maryland Bai | timo | re Cour | nty | Phoe | nix | | | | | | | | | | 2 XINO |
| Maryland 28a-f show d at once. | <u>;</u> | I0e. Street and Number | | | | | | 10f. Zip C | ode | | | | 10g. (| Citizen of Wha | at Count | try? | |
| th the Maryland 23a or 28a-f sho notified at once | 5 | 2729 Paper M | ill | Road | | | | | 211 | .31 | | | U | nited : | Stat | ces | |
| with th | <u> </u> | 11. Marital Status | | 12. Was De | | er in U.S. | | Decedent | | | | ecify Yes or N | 40- | 14. Race - White, | | an Indian, Bl | ack, |
| hours after death with the Maryland natural", or items 23a or 28a-f sheExaminer must be notified at once | Funeral | 1 Never Married 2 | XMarrie | Armed I | | No | | | | | T GOILG ! | | | | Wh: | i + 0 | |
| fter o | <u>-</u> | 3 Widowed 4 | _ | ed If Yes, Give Ye or Dates: | | | | Yes 2 | | | | | - | Specify: | | | |
| 5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner | | 15. Decedent's Education | (Specify | | | | | s Usual O | | | | | 16 | b. Kind of Bus | iness/Ir | ndustry | |
| | Completed | Elementary/Secondary (|)-12) | | (1-4 or 5+) | | | | _ | | | | _ | | 1 | D 1 | |
| O3(orthin or tha Media | ᇍ | 12 | | n/a | ∄ ——— | | Auto | Part | | | | (Eiret Middle | | uto Pa: len Surname) | rts | Deate. | rsnip |
| 15-003 filed within Hygiene. d other th , the Medi | | 17. Father's Name (First, N | | | 1 | | | | | | | | , 141414 | ion ouniano, | | | |
| 121 Ild be fill Mental F marked event, | _ | Joseph Bonave 19a. Informant's Name/Rel | | | cker | 110 | h Mailing | Address | | Jean | | | umber | , City or Town | . State. | Zip Code) | |
| MD 21214 d 2 should be fill th and Mental F n 27 is marked numatic event, i | -1 | | | | , | 1 | | | | | | | | | | | - 1 |
| ME alth a m 27 | 1 | Mrs. Joan El 20a Method of Disposition | en_v | <u>vorrall</u> | (Wlie | 20b. Place | /29 1 of Dispos | Paper ition (Name | of cem | L KC etery, | ad_ | Date | 20 | Maryla: Oc. Location - | City or | Town, State | |
| more, MD 21215-0036 Pages I and 2 should be filed within 72 rent of Health and Mental Hygiene, ant: If item 27 is marked other than " or other traumatic event, the Medical | | 1 Burial 2 X Cre | nation | 3 Removal | from State | crema | tory or oth | ner place) | | - 1 | 0. | 4 10 n | 6 | orest 1 | 1 | 1 14 . | , , , |
| Page Page nent o | | 4 Donation 5 Ot | ner Spec | ify: | | Evans | | | _ | | | 1.11,0 | F. | orest . | Hll. | I,Mary | land |
| Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other transmatic event, the Medica | | 21. Signature of Funeral S | ervice Lic | ensee | Ai. | . 0. | Pea | ame and A | ddress LA1 | of Facility .terr | , lativ | es Fu | ner | al&Cre Maryla | mat: | ion Ct | r.,P.A |
| 00 8.0 1 | ┙ | 23a aryl. Enter the disea | | | Jav | aboth Don | 23: | 25 Yo | ck F | Road | ardiac or | monium respiratory | m . | Maryla shock or hea | nd_ ırt | 21093 Approxima | te Interval |
| Physician | Ì | failure. List only one | se, or co cause on | each line. | , | | | | | | | | | | | Between (| Onset and ath |
| /Medical Examiner | Ì | Immediate Cause (Final d | | | | e athero | scler | otic c | ardio | ovascu | ılar (| 11sease | | | | 1 | |
| | - | or condition resulting in de | atri) | Due to (or as | s a consequ | uence of): | | | | | | | | | | | |
| | ۱. | Sequentially list condition if any, leading to immedia | | Due to (or as | s a consequ | uence of): | | | | | | | | | | | |
| | 틝 | cause. Enter Underlying (Disease or injury that init | Cause | C | | | | | | | | | | | | | |
| n it | Examine | events resulting in death) | | Due to (or as | s a consequ | uence of): | | | | | | | | | | | |
| | | | | d | | | | | | | | | - | | | | |
|), be ex sician urial | edical | X UNPENDED | | AMENDE | #23a | ,27, perl | | 62 , 12 | /5/0 | 5 TT_ | | | | 23d. Date of | deliver | <u> </u> | |
| 760, icate be of physicia the buria | ξ | IF FEMALE: 23b. Was decedent pregna | nt in the | 23c. If ye | s, outcome e birth | of pregnanc | y a 🗀 Fe | etal death | 3 | Ectopi | c pregna | incy | | Month | |) Day | Year |
| certif | iai | past 12 months? | | 4 Pre | gnant at tir | ne of death | | ther (Spec | | | | | | | | | |
| , P.O. Box 68' res that the death certifications signed by the attending | Physiciar | 1 Yes 2 No 9 | Unkno | 3 011 | known | | | | | | | | | | | | |
| O. E | | Part II. Other significant | conditio | ns contributing | g to death t | out not result | ing in the | underlying | cause g | iven in Pa | art I. | | | cco use contri | | | |
| P.O es that the signed by be detac | d by | <u> </u> | | | | | | | | | | | | 2 No 3 | | | |
| cords, law requi has been | ete | | | | | | | | | | | 24a. W au | as an atopsy | l p | prior to | itopsy finding completion of | |
| col | Completed | | | | | | | | | | | | erforme | od? c | death? ✓ Ye | es 2 | No |
| Division of Vital Records, tal or Attending Physician: The law requirers after death. "I Director: After this certificate has been silled in by the funeral director, page 2 should be | | 25. Was case referred to | nedical | T | - | | | 2 | 6.Place | of Death | (Check | only one) | | | | | |
| ital sician s cert recto | Be | examiner? | | Hospital: | Inpatien | 2 🗸 ER/ | Outpatien | t 3 D | DA . | Other ₄ | Nursir | ng Home 5 | Re | sidence 6 | Othe | r. | |
| of Vi | P. | 1 Yes 2 | 10 | 28a. D | ate of Injury | / 28t | . Time of | Injury 2 | 8c. Inju | ry at Wor | k? | 28d. Descri | be hov | v injury occurr | ed | | |
| ion of vending Pheath. | ion | 1 X Natural 5 | Pendir | | onth, Day,Yea | ar) | | - 1 | 1 ` | Yes 2 | No | | | | | | |
| VISION or Attendufter death free death Director: | icat | 2 Accident | Investi | 28e P | lace of Inju | ry - At home, | farm, stre | eet, factory, | office b | ouilding, e | etc. | | | eet and Numb | er or Ru | ural Route Nu | ımber, City |
| Divi | Certification: | 3 Suicide 6 Homicide | Could determ | not be | | | | | | | | or Tow | n, Stat | (6) | | | |
| Ospit Nour Nour Signification | | 29a. Certifier | vina Phy | rsician: To the | best of my | knowledge. | eath occu | urred at the | time, d | ate and p | lace, and | due to the | cause(| s) and manner | r as sta | rted. | |
| Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by it completely filled in by the funeral director, page 2 should be detached. | Medical | (Check only one) 2 Medi | al Exam | iner: On the ba | sis of exam | ination and/c | r investiga | ation, in my | opinior | n, death o | ccurred | at the time, d | late an | d place, and o | due to th | ne cause(s) | |
| To To Com | Mec | 29b. Signature and title of | certifier | and mann | er stated. | | | 290 | Licens | se numbe | г | | 2 | 29d Date sign | ed (Mo | onth, Day, Yea | ir) |
| | | 11 |)/. | V | | | | | O.C. | M.E. | | | | October 16 | 5, 200 | 6 | |
| | | 30. Name and address of | person | who completed a | cause of de | eath (Item 23 | a) | | _ | | | | | | | | |
| | | Theodore M. Ki | | | stant Me | edical Exa | miner | 111 Pe | nn St | reet, B | altimo | e, MD 21 | 201 | | | | |
| 9 | tate | at Date Clark (to all De | | | | s Signature | | | | | | | | | | | |
| Regis | | | | 2006 | Bogue. | . Jr. | Ans. | No. | | | | | | | | | |
| DHMH 17 Rev 1/2 | | | U | | | C | RIGIN | AL | | | | | | | | | |

| | | | For State Registrar | | State of | Marylar | | artment rtificate | | | | 1ental Hy | giene Reg. No. | 00 |)6 | 37832 |) |
|---------------------|---|----------------|---|---|--|----------------------------------|----------------------------------|----------------------------|-------------------|----------------------------|-----------------|-----------------------------------|-----------------------------|-----------------------|----------------------------|--------------------------------------|---|
| | | | 1. Decedent's Name (| First, Middle, L | ast) | | | | | | | 2. Date of De | eath Day | | V | 3. Time of Death | _ |
| | Physici /Medio | | Nina | Steinb | 4-9 | | | | | | | Nov | | 7 | Year 2006 | 8:50 AM | |
| | Examir | | 4a. Facility Name (If no | ot institution, g | ive street and numb | oer) | | 4b. City, | Town, or | Location | of Death | | 4c. C | ounty | of Death | | _ |
| | | | Howard Cou | inty Ge | neral Hos | pital | | Co | lumb | oia | | | | How | ard | | |
| | Funeral | | 5. Social Security Num | iber 6. | Sex 7. 1 ☐ M 2 🔀 F | | last birthday) | If Under Months | 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bir (Month, Da | av. Year) | | 9. Birthpla | ace (State or Foreign ry) Dama | 1 |
| | Director | | 578 12 093 | | 2021 | 86 | Yrs. | | | | | May 27 | , 192 | 0 | Alak | oáma | _ |
| | end ** | | Usual Residence of Do 10a. State 1 | Ob. County | | 10c. Ci | ty, Town or Lo | cation | | | | | | | 10 | d. Inside City Limits | _ |
| | Mary feh | ō | MD | Howard | | Col | lumbia | | | | | | | | | 1 ☐ Yes 2 No | |
| | 1he | Director | 10e. Street and Number | | | | - CARLOTA | 10f. Zip | Code | - | | | 10g. Citize | n of W | hat Count | ·w? | _ |
| | 3a or | | 6336 Cedar | Lano | Ant 2/19 | | | | 044 | | | | | | Stat | • | |
| | me 2 | Funeral | 11. Marital Status | . IXIIC I | 12. Was Deced | ent Ever in U | J.S. 13. 1 | | | spanic Ori | gin? (Sp | ecify Yes or No Rican, etc.) | | . Race | - America | ın Indian, | - |
| 9 | or its | 교 | 1 Never Married | 25 Married | | ₹ No | | | | | | Rican, etc.) | | Black | , White, e | itc. | |
| 93 | ref., | ğ | 3 Widowed 4 [| Divorced | If Yes, Give Year or Date | es: | | 1 ☐ Yes 2 | No No | Specify: | | | S | pecify: | Whi | ite | |
| 5-0 | within 72 hours after death with the Marylend ene. then "naturel", or iteme 23a or 28a-f ehow the Madical Examinar mail be notified at | Completed | 15 (Specify | i. Decedent's I | Education rade completed) | · · | 16a. Dece | dent's Usua kind of won | l Decupa | ition | t of work | ina | 16b. Kind | of Bus | iness/Indi | ustry | |
| 21 | within then then | ig I | Elementary/Second | | College (1-4 | or 5+) | life. | no no tus Memak | e retired) |) | | 9 | ~. | ∽ TT | ~ | | |
| 2 | filed v Hygie other t | | 17. Father's Name (Fir | | | | пс | Menak | er | | | | | | ome | | _ |
| Maryland 21215-0036 | S d la D | To Be | William Kr | | st) | | | | | | | e (First, Middle Hunter | , Maiden Si | <i>ım</i> am <i>e</i> |) | | |
| ary | A DEE | - | 19a. Informant's Name | e/Relationship | (Type, Print) | | 19b. Mailir | ng Address | (Street a | nd Numbe | er or Rura | al Route Numb | er, City or T | own, S | State, Zip (| Code) | - |
| | s 1 and 2 of Health a item 27 is other tran | | J. David S | teinbe | rg/Husban | d | 6336 | Cedar | Lan | e Ap | t 24 | 9 Colum | bia, | MD | 21044 | 1 | |
| ore | | | 20a. Method of Dispos | | | . ! (| Place of Dispo | natory or ot | her place | 9) | | Date | 20c. Loca | tion - C | City or Tow | vn, State | |
| Ĕ | Pages nent of ant: If its arry or o | | 4 Donation 5 | | □Removal from St :ify) | Cro | wnsvil | le Ve | t. C | ém. | 12–1 | -2006 | Crown | svi | lle, | MD | |
| Baltimore, | permit. Page Depertment of Important: If any Injury or once. | | 21. Signature of Fune | ral Service Lice | ensee - HA | M0104 | 14 22 | 12 01 | d Address | s of Facilit | Har | ry H. W | itzke | 's : | Famil | Ly FH Inc. ND 21043 | |
| | | | 23a. Part1. Enter the | disease, or con | mplications that cau | the death | h. Do not ent | er the mode | ol dying | , such as | cardiac o | or respiratory a | rrest, | | | Approximate Interval Between | |
| | Physician | | Immediate Cause (Fir disease or condition | | | | c ch | . K | Can | 6. 4 | | | | | | Onset and Death | |
| 1 | /Medical | | resulting in death) | - | Due to (or | as a conseq | c sh | , , , | 24 | 117 | | | | | | Hours | _ |
| | Examiner | | Sequentially list condit | tions. | b | Pnec | Monia | | | | | | | | | Pays | |
| 7 | ad sit | ine | Sequentially list condition any, leading to inmecause. Enter Underlyi Cause (Disease or injuries) | ng 2 | Dila to (or | as afour seq | rushes of): | | | | | | | | | , | |
| V | and and i-tran | Examine | that initiated events resulting in death) Las | | c. Due to (or | as a conseq | uence of): | | _ | | | | | _ | _ | | _ |
| 8760, | certificate be executed nding physicien and use as the burial-transit | aiE | | | | | 31, | | | | | | | | | | |
| 687 | phy s the | edicai | | | d | | | | | | | | | | | | |
| Box | eath certif attending for use as | N/W | IF FEMALE: 23b. Was decedent pr | ennant | 23c. If yes, outco | | | | | | | | 230 | Date | of delivery | v | |
| | death | cia | in the past 12 mg | nths? | 4 ☐ Pregnar | n 2∏Feta atattinne old | | Ectopic pre Other (spe | gnancy cify) | | | | 250 | Mont | | y Day Year | |
| P.O. | thet the di ed by the detached | Physician/Me | 9 Unknown | | 9□ Unknow | n | | | | | | | | | | | |
| | | by P | Part II. Other significa | nt conditions | contributing to deal | h but not res | ulting in the ur | nderlying ca | use give | n in Part I. | | 23e. Did t | obacco use | contrib | oute to the | cause of death? | |
| ğ | w requires been sign should be | | | | | | | | | | | 10 | Yes 2 🖭 | Vo 3 | Probal | bly 4 ∐Unknown | |
| သူ | S S S | pie | | | | | | | | | | 24a. Was | | 24b. W | ere autops | sy findings available | |
| <u>~</u> | The ete h page | Completed | | | | | | | | | | | rmed? 2₽No | de | ath? | pletion of cause of | |
| ita | Physician: The this certificete | Be (| 25. Was case referred examiner? | to medical | | | | | | 26. Place | of Death | Check only o | | | | | - |
| Ž | S 0 70 | 2 | 1 ☐ Yes 2 ☐ Mo | | Hospital: 1 1 thp | atient 2 🗆 | ER/Outpatien | t 3 DO | Other | r: 4 □ Nu | rsing Hor | me 5 ☐ Resi | dence 6 | Other | (Specify) | | |
| ם | ding Phi th. After thi funeral | ë | 27. Manner of Death 1 Natural | 5 ☐ Pending | 28a. Date of (Month, | Injury Day Year) | 28b. Time of Injury | 28 | c. Injury Work | at ? | 1 | 28d. Describe I | now injury o | ccurre | d | | _ |
| <u>s</u> io | Attending r death. Cotor: After by the fune | cati | 2 Accident | investigation i | he | | | М | | es 2 🗆 f | | | | | | | |
| - | l or Atten after deat Director: I in by the | Certification; | 4 Homicide | determine | 286. Place of | Injury - At hi , etc. (Specif | ome, farm, stre y) | eet, lactory, | office | | 1 | 28l. Location (: City or To | Street and N vn, State) | /um <i>ber</i> | or Rural I | Route Number, | |
| | To the Hospital or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the | edical C | 29a. Certifier 1[(Check only 2[one) | Medical Exa | hysician: To the beaminer: On the basi | s of examina | wledge, death tion and/or inv | occurred a restigation, i | t the time | e, date and inion, deat | d place, a | and due to the ed at the time, | cause(s) an date and pla | d man | ner as stat id due to t | ted. he cause(s) | - |
| | To the within 2 To the complet | Me | 29b. Signature and title | of certifier | | | | 29c. | License | number | | | 29d. Date s | igned (| (Month, Di | ay, Year) | _ |
| | | | 1/50 | | M | | | 1 | 7-53 | 3636 | , | | Nov | 27 | 200 | 6 | |
| | 10 | | | of person who | completed cause | of death (Item | п 23а) (Туре, | <u> </u> | | | | | | | - | | _ |
| | 1 | | | Carlso | 7,40 | 1070 | o cha | the | ans | c Co | hont | in Me | 210 | 44 | ! | | |
| | Sta Registr | | 31. Date filed (Month, I | NOV 2 | 32. Reg | ismar's Signa | ture | Speak | 2 | | | | | ٠ | | | |

4b. City, Town, or Location of Death

State of Maryland / Department of Health and Mental Hygien U U O

2. Date of Death Month

NOV

| 1- | For State Registrar |
|----|---------------------------|
|----|---------------------------|

1. Decedent's Name (First, Middle, Last)

William Paul Stern

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner

Certificate of Death

25

Year

2006

4c. County of Death

6:45 PM

| | | | 1105 Ha | rwall R | oad | | | Woodlaw | m | | |] | Baltim | ore | |
|---------------------|---|----------------|---|-------------------------------------|------------------------|---|-----------------------|--|-------------------------------|--------------------------------------|------------------------------------|----------------------------|------------------------------|-------------------|------------------------|
| | Funeral Director | | 5. Social Security N 214-62-3 | | Sex 1∰M 2□F | 7. Age (In yrs. I | ast birthday) Yrs. | If Under 1 Year Months Days | If Under Hours | Min. | Date of Bi (Month, Da ug. 14 | rth ay. Year) 4, 195 | 9. Bird Co 55 Man | thplace (sountry) | State or Foreign |
| | п | | Usual Residence of | Decedent | _ | | | | | | | | | | |
| | lane | | 10a. State | 10b. County | | 10c. City | , Town or Loc | ation | | | | | | 10d. Ins | side City Limits |
| | e Many | Director | Maryland | Balt: | imore | | Wood1 | .awn | | | | | | 1[|]Yes 21⊠ No |
| | h th | - e | 10e. Street and Nur | mber | | | | 10f. Zip Code | | | | 10g. Citize | on of What Co | ountry? | |
| | 23a c | la D | 1105 Har | wall Roa | ad | | | 21207 | | | | USA | | | |
| | ep E | ne | 11. Marital Status | | 12. Was Dec Armed F | edent Ever in U. orces? | S. 13. V | as Decedent of H Yes, specify Cuba | lispanic Ori | rigin? (Spec | ify Yes or Nican, etc.) | 0- 14 | I. Race - Ame Black, Whit | | ian, |
| 036 | | by Funeral | 1 X Never Marri 3 Widowed | ied 2□ Married 4 □ Divorced | | 2 XNo ive | | ☐ Yes 2 No | | | , | | Specify: | USA | |
| Maryland 21215-0036 | permit. Pages 1 end 2 should be filed within 72 hours Depertment of Heelth and Mentel Hygiene. Importent; if Item 27 is marked other then "naturel", eny Injury or other treumatic event, the Medical Exp once. | Completed | | 15. Decedent's cify only highest | grade completed, | | 16a. Deced (Give) | ent's Usual Occup kind of work done OO NOT use retired | ation during mos | st of working | 7 | 16b. Kind | d of Business | /Industry | |
| 212 | d with giene. | mo: | Elementary/Seco | indary (0-12) | College | (1-4or 5+) | | odian | | | | Ent | ertair | ment | : |
| Ö | other ant. | Oe | 17. Father's Name | (First, Middle, La | st) | | | | 18. Moth | er's Name (| First, Middle | . Maiden S | umame) | | |
| vlan | Mente Mente arked attc ev | To Be | Robert | E. Stern | 1 | | | | Na | aomi A | . Tay | lor_ | | | |
| a | and and | | 19a. Informant's Na | | (Type, Print) | | 19b. Mailin | g Address (Street | and Numb | er or Rural | Route Numb | per, City or | Town, State, | Zip Code |) |
| Σ | elth 27 I | | Naomi S | tern | Mot | her | 1105 | Harwall | Road; | Wood | lawn, | Mary] | land 2 | 1207 | |
| ē | of He Item | | 20a. Method of Disp | | - | | tace of Dispos | sition (Name of plan | ce) | Da | te | 20c. Loca | ation - City or | Town, S | tate |
| <u> </u> | Page ment cent; if ent; if ury or | | | Cremation 3 5 ☐ Other (Spe | | State | ional | Cremator | v | 11-29 | -2006 | Falls | Churc | ch, V | rginia |
| Baltimore. | permit. Deperti | | 21. Signature of Fu | uneral Service Lic | ensee | 200 | Fu 16 | Name and Addre neral Ho 30 Edmon | ss of Facili me of dson | _{ity} Ster Cato Avenu | ling-A nsvill e; Cat | Ashton Le, In tonsvi | i-Schwa ic 11e, M | ib-Wi D 21 | .tzke .228 |
| | | | 23a. Part1. Enter to shock, or hea | he disease, or o | mplications that | caused the death | n. Do not ente | er the mode of dyir | ng, such as | cardiac or | respiratory a | arrest, | | Appr | oximate val Between |
| | Physician | | Immediate Cause | (Final | d | ann A | 20044 | _ | | | | | | Onse | t and Death |
| | /Medical | | resulting in death) | | aDue to | (or as a consec | itence of): | | | | | | | 7 | ears |
| | Examiner | | Sequentially list co | nditions | Con | restive | Lhoa | rt fail | ure | | | | | Y | cars |
| 7 | D = | ner | Sequentially list co if any, leading to in cause. Enter Under | nmediate | Due to | (or as a conseq | uence of): | | | | | | | | / |
| V | executed in and ial-transit | Examiner | that initiated events | injury | c. M | pidre | Obes | ity | | | | | | | ears |
| 9 | e exe cien al rurial-t | EX | resulting in death) | Last | Due to | (or as a consequ | uence of): | , | | | | | | | |
| 876 | cate t | dlca | | | d | | | | | | | | | | |
|). Box 68760. | o death certificate be executed to ettending physicien and ed for use as the buriat-transit | sician/Medical | IF FEMALE: 23b. Was decedend in the past 12 1 Yes 2 (| months? | 1 ☐ Live | utcome of pregna birth 2 Fetal mant at time of de | death 3 | Ectopic pregnancy Other (specify) | у | | | 23 | 3d. Date of de Month | livery Day | Year |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

mellitus, Type II

Hospital: 1 Inpatient

28a. Date of Injury (Month, Day Year)

| | | | | | and Death |
|---|-------|---|--|---------------------------|-------------------------------|
| ilure. | | | | Y | ars |
| | | ****** | | Ye | eurs |
| | | | | | |
| ancy | | | 23d. Date of de Month | olivery Day | Year |
| given in Part I. | | 23e. Did tobacc | o use contribute t | | of death? |
| | | 24a. Was an autopsy performed 1 Yes 2 | prior to death? | completion | ings available of cause of |
| 26. Place of Dea | | | | | |
| 4 □ Nursing H | - | | | ecify) | |
| Injury at Work? 1 □ Yes 2 □ No | 28 | d. Describe how in | ijury occurred | | |
| ice | 281 | Location (Street City or Town, St | and Number or Rate) | lural Route | Number, |
| ne time, date and place my opinion, death occu | , and | d due to the cause at the time, date a | e(s) and manner a and place, and du | s stated. e to the cau | ıse(s) |
| cense number | | 29d. [| Date signed (Mon | th. Day. Ye | ar) |

To the Hospital or Attending Physician: The law requires that the di within 24 hours effer death.

To the Funeral Director: After this certificate hes been signed by the completely filled in by the funeral director, page 2 should be deteched Division of Vital Records, P.O.

Physi δ Completed Be Certification: Medical

State Registrar

Benjamin S. 31. Date filed (Month, Day, Year)

29b. Signature and Attle of certified

9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident 3 Suicide

4 - Homicide

(Check only one)

29a. Certifies

Hypothyroidism

5 Pending investigation

6 Could not be determined

D52544 Nov. 28, 2006

h (Hem 23a) (Type. Print)

h OD Geipe Pd #204, Catonsville, UD 21228 Lee, U.D. 32 Registrar's Signature

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place,

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.

Mysician who completed cause of death (Item 23a) (Type, Print)

28b. Time of Injury

3 DOA

28c. Injury at Work?

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37834 Certificate of Death Reg. No. U U 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 26 2006 **Physician** REBECCA SNYDER 10:05 P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUNRISE OF PIKESVILLE BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 11/06/1915 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) MAINE 91 140-34-0728 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits show ral", or Items 23a or 28a-f shov Examiner must be notified at Director MD BALTIMORE BALTIMORE 1 ☐ Yes 2 👿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 OLD COURT ROAD 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. δ WHITE 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) than " Elementary/Secondary (0-12) CLINICAL PSYCHOLOGIST **PSYCHOLOGY** If item 27 is marked other or other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOUIS SNYDER IDA REIF 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) INA LEBOE / NIECE 10 STIRRUP COURT - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any Injury or once. 4 Donation 5 Dother (Specify) BETH JACOB CEMETERY 11/28/2006 FINKSBURG, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Mari LE 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAGE **Physician** DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ASCULAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No certificate has b irector, page 2 sl 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Certification: To 1 | Yes 2 | No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No nours after death. neral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check one) and manner stated.

State

Registrar

31. Date filed (Month, Day,

30. Name and address of person who

29b. Signat

RWER NECK AS \$ 109 201, BACK

completed cause of death (Item 23a) (Type, Print)

29c. License number

00060560

29d. Date signed (Month, Day, Year)

Poticnt known as: Zelda S. Strin

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 本

| | | Pleas | e Type or | Print in E of Marylan | | | | | | | | _ | |
|--|---|--|-------------------|--|--|--|------------------------|----------------------------|------------------------|--|-------------------------|--------------------------------|---|
| | | For State Registrar | Otato | i waiyiai | • | tificate | | | 2110 10 | 1011101111 | Reg. No | 71111 | 5 37835 |
| Physicia | | 1. Decedent's Name (First, Middle, | Last) | | | | | | | 2. Date of Do Month | Da | у Үөа | 3. Time of Death |
| /Medica | | ZELDA | | | | | TEIN | | | NOVEMB | | 3 2006 County of De | |
| Examine | | 4a. Fecility Name (If not institution, g | \L | | I | If Under | | BALT If Under | IMOR | | | | N/A |
| Funeral Director | | 215-10-1972 | Sex 1 M 2 F | 7. Age (<i>In yrs.</i> 90 | ,. | Months | Days | Hours | Min. | 8. Date of Bi (Month D 01/16/ | 1916 | 9. 8 | irthplace (State or Foreign Country) MD |
| show | | Usual Residence of Decedent 10a. State 10b. County MD N/ | ٨ | 10c. Cit | ty, Town or Loc | cation | F | | | | | | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No |
| after death with the Maryland or Itema 23s or 28s-f show mer neat the notified at | Director | 10e. Street and Number | | UL #706 | | 10f. Zip | | 212 | 1 5 | | 10g. Cit | izen of What | Country? |
| eath v | Funeral | 7121 PARK HEIG | 12. Was Dec | edent Ever in U | | Vas Deced | ent of His | 212. | | ecify Yes or N | 0- | 14. Race - Ar | nerican Indian, |
| or Ite | 2 | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced | Armed F | orces? 2[X]No ive | 11 | Yes, spec | rfy Cubar | Specify: | n, Puerto | Rican, etc.) | | Black, Wi | WHITE |
| permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, I'm Madical Exa once. | Completed | 15. Decedent's (Specify only highest : Elementary/Secondary (0-12) | grade completed, | 1-4or 5+) | life. L | lent's Usua kind of wor DO NOT us EMAKE | k done d e retired) | uring mos | t of work | ing | | ind of Busines | , |
| Jid be filed Aental Hygie rked other tic event, | lo Be C | 17. Father's Name (First, Middle, La | est) | | SIM | ON | | | er's Namo DNA | e (First, Middle | , Maiden | Sumame) | ADAVITZ |
| and 2 shore salth and N n 27 is ma | Actor Control of the | 19a. Informant's Name/Relationship | | | | 3 | , | | | a <i>l R</i> oute <i>Numb</i> ENUE #7 | , , , | | MORE, MD 2121 |
| Pages 1 ament of He ment: If Item ury or oth | | 20a, Method of Disposition 1 \(\Delta \) Burial 2 \(\Delta \) Cremation 3 4 \(\Delta \) Donation 5 \(\Delta \) Other (Spe | | State | Place of Disposemetery, cren LTIMOR | natory or of | her place | 1 | | 8/2006 | | ALTIMO | RE, MD |
| permit. Departingorti | | 21. Signature of Funeral Service Lie | censee | | | . Name an | | | | | | | S., INC. |
| Physician /Medical Examiner | | 23a. Part1. Enter the disease, or conditions shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) | a | caused the deal | ohayy | 2111011.10 - 2 | | g, such as | cardiac | | | | E, MD 21208 Approximate Interval Between Onset and Death |
| . 99 5 26 11 | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | с | (or as a consection of the consection) | kinso | 'n' | dik | are. | | | | | |
| The law requires that the death certificate be estate has been signed by the attending physicien page 2 should be detached for use as the burial | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 1 ☐ Live | itcome of pregn birth 2 ☐ Feta nant at time of c nown | al death 3 | Ectopic pro | | | | | | 23d. Date of o | delivery Day Year |
| quires thet n signed by | 2 | Part II. Other significant condition | s contributing to | death but not res | sulting in the ur | nderlying ca | ause give | en in Part I | | 1 | | P | to the cause of death? Probably 4 □Unknown |
| | Completed | | | | | | | | | perf 1 ☐ Yes | opsy ormed? 20 No | prior t death | autopsy findings available o completion of cause of ? es 2 \(\text{No} \) |
| ysician: S s certifice director, p | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | Inpatient 2 | ER/Outpatien | t 3 DO | Othe | 200 | | h <i>(Check only</i> ome 5 ☐ Res | | 6 ∏Other (S | necify) |
| ng Phy (fter thi | ation: I | 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga | 28a. Date (Mo | of Injury oth, Day Year) | 28b. Time of Injury | | Bc. Injury Work | | | 28d. Describe | | | |
| To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the t | Certification: | 3 ☐ Suicide 6 ☐ Could no determin | 280. Plac | e of Injury - At h ding, etc. (Speci | nome, farm, str fy) | eet, factory | , office | | | 28f. Location City or To | | | Rural Route Number, |
| To the Hospital or within 24 hours afte To the Funeral Dir completely filled in | Medical | 29a. Certifier 1 Certifying (Check only one) 1 Medical Ex | | e best of my knobasis of examination | owledge, death ation and/or inv | occurred vestigation, | at the tim in my of | ne, date an pinion, dea | nd place, ath occur | and due to the red at the time | cause(s , date an |) and manner d place, and d | as stated. lue to the cause(s) |
| To the vithing complete the transfer of the tr | 2 | 29b. Signature and title of certifier | W | V | | | 0 | number | 200 | 25 | | 11/29 | onth, Day, Year) |
| | | 30. Name and address of person w | 1110 | 270 | 400 | | Cof | Cou | 1 | Rdj | Ba | 15m | on, Porney |
| Stat Registra | | 31. Date filed (Month, Day, Year) NOV 3 0 | 2006 | egistrar's Sign | ature of | soil | , | | | | | | |

| | | 1 | For State | | State of Ma | arylan | | artment of H | lealth and N | | giene | 006 | 37836 |
|--|--|-------------------|---|--|---|-----------------------------|---------------------------------------|---|---|--|-------------------------|-----------------------------------|--|
| - 37 | Physicia | | Registrar 1. Decedent's Name | (First, Middle, Last) | TE di- | Ha | | romas | | 2. Date of Dea | ath Day | 19, Year | 3. Time of Death |
| | /Medic Examin | al - | 4a. Facility Name (If | not institution, give | A / | l VI | Carto | | r Location of Death | Novem | | County of Deal | |
| | Funeral | | 5. Social Security No | 4.5 | | i / 0 e (In yrs. 1 83 | ast birthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day Jan 17, | h v, Year) | 9. Bird | hplace (State or Foreign |
| | Director | | 215-14-93 Usual Residence of | Decedent | | | , Town or Lo | cation | | Jan 1/, | 192 | 3 | 10d. Inside City Limits |
| | Marylar a-f show | tor | MD State | Baltimore | 7 | 100. 010 | , town or Lo | Cation | | | | | 1 □ Yes 2 🛣 No |
| | with the | Funeral Director | 10e. Street and Nun | | | | | 10f. Zip Code 21227 | | - | 10g. Citiz U • S • . | zen of What Co | ountry? |
| | eath ne 23 | eral | 4942 Tuli | tp Avenue | 12. Was Decedent | Ever in U | S. 13. | Was Decedent of H | lispanic Origin? (Sp | ecify Yes or No | | 14. Race - Ame | |
| 920 | J within 72 hours after death with the Maryland jiene. Than "natural", or Iteme 23e or 28e-f show I're Madical Examir er must be notified at | þ | | ed 2 Married 4 Divorced | Armed Forces? 1 ☐ Yes 2 ☑ f If Yes, Give Year or Dates: | | | If Yes, specify Cuba 1 ☐ Yes 2 ☑ No | an, Mexican, Puerto Specify: | Rican, etc.) | | Black, Whit | |
| 21215-0036 | hin 72 ho s. nn "natur Medical | Completed | (Spec | 15. Decedent's Edu ify only highest grad | | 5+) | (Give | dent's Usual Occup kind of work done DO NOT use retired | during most of work | king | 16b. Kir | nd of Business | /Industry |
| CA | 71 75 - | Con | 12 | | | | Caregi | ver | 18. Mother's Nam | | | th Care | 2 |
| Maryland | b d ta b | To Be | 17. Father's Name (Benjamin | | | | | | Edith Vi | | | | |
| Mary | and and is m | | | ame/Relationship (7) | | nter | 4 | • | and Number or Ru ive Littl | | | | Zip Code) |
| Baltimore, | Pages 1 and 2 ent of Health nt: If item 27 ry or other tru | | | oosition Cremation 3 DF 5 Other (Specify, | | 20b. F | Place of Disponentery, cre COD She | osition (Name of matory or other pla pherd Cen | etery 11 | Date -25-200 | | cation - City or Licott | |
| Balti | permit. Pages. Department of h Important: If ite any injury or of | | | neral Service Licens | | olie | An 13 | Name and Address Drose Fu 328 Sulph | neral Hon ur Spring | ne, Inc. Rd. Ar | butu | s MD 21 | .227 |
| 17 | Physician | | shock, or hea Immediate Cause disease or condition | he disease, or comp nt failure. List only o (Final on | lications that caused ne cause on each li | d the deat | h. 🕍 noten | ter the mode of dyii | ng, such as cardiac | or respiratory a | rrest, | | Approximate Interval Between Onset and Death V-UVJ |
| 1 4 | /Medical Examiner | | resulting in death) | | Due to (or as | | | son's o | hiseas | e | | | Verus |
| | pet William | Examiner | Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or | enditions, nmediate erlying intury | Due to (or as | a consec | | | | | | | |
| 8760, | e be execu rsicien and e burial-tra | cal Exa | that initiated events resulting in death) | Last | Due to (or as | a consec | uence of): | | | | | | |
| 9 | tificat ng phy as th | ledi | 15 55 MM 5 | | | | | | | | | | |
| O. Box | law requires that the death certificate be executed as been signed by the attending physicien and as been signed by the attending physicien and so should be detached for use as the burial-transit. | Physician/Medical | IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown | months? | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown | 2 Feta | Ideath 3 | □Ectopic pregnand □ Other (specify) _ | У | | ; | 23d. Date of de Month | olivery Day Year |
| rds, P.O. | quires that t n signed by uld be detac | | Part II. Other signi | ficant conditions co | entributing to death the | but not res | sulting in the | underlying cause gr | ven in Part I. | | Yes 2 | | to the cause of death? |
| Division of Vital Records, | hysician: The law requir his certificate has been si i director, page 2 should | Completed by | Histor | y of ce | rebral | Va | sculo | nr acci | dent | 24a. Was auto perfo 1 🗆 Yes | | prior to | |
| /ita | cian: sertific ector, | Be | 25. Was case refe examiner? | ^ | Hospital: | | | Ot | 26. Place of Dea | | | | |
| of | Physic ruthis creal direction | . To | 1 ☐ Yes 2 X | NO | 1 ☐ Inpati 28a. Date of Inj (Month, Da | - | 28b. Time | INT 3 DOA | 4 Nursing F | lome 5 Resi | | | ecity) |
| ion | Attending Physician: The r death. ctor: After this certificate hey the funeral director, page | ation | 1 Natural 2 Accident | 5 Pending investigation | | ay Year) | Injury | | ork?]Yes 2 □No | | | | |
| Divis | el or Atte s after de il Directo id in by th | Certification: | 3 🗍 Suicide 4 🗍 Homicide | 6 Could not be determined | 28e. Place of In building, e | njury - At h etc. (Spec | iome, farm, s fy) | treet, factory, office | | 28f. Location (City or To | Street an wn, State | nd Number or F 9) | Rural Route Number, |
| | To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral dil | edicai (| 29a. Certifier (Check only one) | Certifying Ph 2 Medical Exam | ysician: To the besi niner: On the basis and manner s | of examin | owledge, dea ation and/or i | th occurred at the to | ime, date and place opinion, death occu | e, and due to the urred at the time, | cause(s date and |) and manner a d place, and du | as stated. se to the cause(s) |
| | To the within 2 To the complete | Me | 29b. Signature and | d title of certifier | my | 77 | Mo | 29c. Licen | se number | | 29d. Da | te signed (Mor | ath, Day, Year) |
| | H | | 30. Name and add | fress of person who | completed cause of | death (Ite | m 23a) (Type | p, Print) | altimor | e Ma | wyl | land | 21227 |
| The state of the s | St Regist | ate rar | 31. Date filed (Mo | | 32. Regist | trar's Sign | ature for | de s | ** * 1 | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 26, 2006 Physician 11:35PM Tammetta Anthony /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 85 1921 Director 143-12-6093 April Í, New Jersey Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 🙀 No MD Baltimore Lutherville filed within 72 hours after death with the Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 8510 Tallwood Road 21093 USA Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Mes 2 □
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 □ No WWII Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 VNo Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Sales d 2 should be filed w th and Mental Hygier 7 is marked other th Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marino Tammetta Angela Mariforta ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 8510 Tallwood Road, Lutherville, MD. Ann Tammetta (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/30/2006 Gardens 4 □ Donation 5 □ Other (Specify) Entombment Dulaney Valley Mem. Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Coster 1050 York Road, Towson, Maryland Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed physician and as the burial-trant Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) n signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? hast autopsy page perform certificate 2 No 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 124 hours after death. 5 ☐ Pending investigation 1 Natural 2 Accident 1 TYes 2 TNo the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 24

State Registrar

29b. Signature and title of certifier

ABDALLAH M.D. 31. Date filed (Month, Day, Year) 3. Registrar's Signature

NOV 2 9 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601 OSLER DRIVE

DHMH 17 Rev 1/2001

29c. License number

D007695

29d. Date signed (Month, Day, Year)

TOWSON. MARYLAND 21204

November 27, 2006

| Deceder's Name (Frest, Michia, Late) Deceder's Name (| | | - | State of Maryland / Depa - State Amend item#26, perMD, g861, II/29/06 Cerd | rtment of Health and Mer | ntal Hygier | 2006 | 37838 |
|--|----------|-------------------------------------|----------|--|---|-----------------------------------|--------------------|--|
| Examiner Examin | | | | | 2. | | | 3. Time of Death |
| ## As Sealing well from statistican to pass where any number As Sealing well production As Sealing | | _ | | MARY BERNARDITA THOMPSON | N | | | 12:45 P.™ |
| Secular Security Numbers 1.5 Security Numbers 1.5 Security Numbers 1.5 Security Numbers 1.5 Security Numbers 1.5 | | | | | 4b. City, Town, or Location of Death | 4 | c. County of Death | 1 |
| Directors Comparison Compa | | | | Maria Health Care Center | | | Baltimo | ore |
| Use a Part Age of the Control 100. State 100. Control 100. State 100. Control 100. State 100. Control 100. State 100. State 100. Control 100. State 100. Control 100. State 100. Control 100. State 100. Control 100. State 100. Control 100. State 100. Control 100. State 100. Control 100. State 100. Control 100. State 100. Control 100. State 100. Control 100. State 100. Control 100. State 100. Control 100. State 100. Control 100. State 100. Control 100. Con | | | | 1 N 2 N 5 | | Date of Birth (Month, Day, Yea | 9. Birth | intry) |
| Total State 100. Copyry 100. Easter 100. Copyry 100. Easter 100. Copyry 100. Easter | | Director | | 218-22-7622 | J | une 29, | 192/ Mar | yland |
| The properties of the properti | | and | | | eation | | | 10d. Inside City Limits |
| The properties of the properti | | Many 1 sh | ğ | Maryland N/A Baltim | nore | | | 1∭Yes 2☐No |
| The properties of the properti | | r 28e | rec | | T | 10g. (| Citizen of What Co | untry? |
| The properties of the properti | | Marit 13a o | <u></u> | 901 Aisguith Street | 21202 | | U.S.A | |
| The properties of the properti | | death | ner | | | y Yes or No- | 14. Race - Amer | ican Indian, |
| The properties of the properti | ဖွ | or ite | F | 1 Never Married 2 Married 1 ☐ Yes 2 No | | 411, 010.7 | | |
| The properties of the properti | 8 | ural', | d b | 3 ☐ Widowed 4 ☐ Divorced Year or Dates: | | 1 | VVII | |
| The properties of the properti | <u>5</u> | nati | ete | (Specify only highest grade completed) (Give k | kind of work done during most of working | 16b. | Kind of Business/I | ndustry |
| The properties of the properti | 12 | withir ane. than | Ę. | Elementary/Secondary (0-12) College (1-4or 5+) | , | į. | Education | n |
| 23a Part. Effect the Seases, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Can Barrier Can Bar | 2 | Hygie ther int, II | | | | irst, Middle, Maid | | 11 |
| 23a Part. Effect the Seases, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Can Barrier Can Bar | an | d be ental ced o | o Be | | Amelia | Fisc | her | |
| 23a Part. Effect the Seases, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Can Barrier Can Bar | Z Z | shoul nd M mari | - | | | | | ip Code) |
| 23a Part. Effect the Seases, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Can Barrier Can Bar | Š | nd 2 allth a 27 le | | Bernice Feilinger, S.S.N.D. 6401 | N. Charles Street | Baltimore | e. Marvla | and 21212 |
| 23a Part. Effect the Seases, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Can Barrier Can Bar | ē, | s 1 a of Hei of Hei ltem | - 8 | 20a. Method of Disposition 20b. Place of Disposition | sition (Name of Date | | | |
| 23a Part. Effect the Seases, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Can Barrier Can Bar | E | Page nent o | | `4 Donation 5 Other (Specify) Villa Mar | | | en Arm, N | Maryland |
| 23a Part. Effect the Seases, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Can Barrier Can Bar | alti | mit. Porte y nju | | 21. Signature of Funeral Service Licensee 22. | Name and Address of Facility | moral H | omo Tno | |
| 23. Part I. Enter the Blassas or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximate and Death (Indication) Indication (Indication) Sequentially list conditions, and and Death (Indication) Sequentially list conditions. Sequentially list c | <u>m</u> | 89 5 8 9 | | George Ferran 6 | 500 York Road Bal | timore, | Maryland | 21212 |
| Privatician | П | | | 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter | or the mode of dying, such as cardiac or re | espiratory arrest, | | Approximate Interval Between |
| Sequentially list conditions course for program of the surface of | | Physician | | disease or condition | | | | 6 months |
| Sequentially list conditions, if any leading to immediate gause. Einer Underlying cause given in Part I. Per part Pe | | | | Due to (or as a consequence of): | | | | |
| Due to (or as a consequence of): Due to (or as a consequence of): | | Lammer | _ | Sequentially list conditions, b. Due to (cross a consequence of): | | | | year. |
| State | | ed tist | ine | rt any, leading to immediate Due to (or as a consequence or). cause. Enter Underlying Cause (Disease or injury | | | | 1070 |
| State | | xecut and al-trar | xan | that initiated events c. | | | | |
| FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Eval death 2 Eval death 2 Eval death 2 Eval | 92 | siciar burii | | C _d | | | | |
| The complete of the cause of death of the death of the death of the cause of death of the death of the death of the cause of death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the d | | fficate p phy as the | edic | V- | | | | |
| The state The | XO | nding use a | n/M | 23b. Was decaded pregnant 23c. If yes, outcome of pregnancy | Estacia accessor. | | 23d. Date of deli | very |
| The state The | | death e atte | icia | in the past 12 months? 4 Pregnant at time of death 5 | | | Month | Day Year |
| The state The | Ö | the by the ache | hys | | | | | |
| Part | | gned be de | | Part II. Other significant conditions contributing to death but not resulting in the un | derlying cause given in Part I. | | | |
| Part | ord | equir en si ould | | | | 1 L Yes | 2 No 3 Pro | obably 4 Sunknown |
| The state of Death of | ec | W 200 | adr. | | | autopsy | prior to c | topsy findings available ompletion of cause of |
| The state of Death of | - H | Th ate pag | Co | | | 1 Yes 2 4 | No 1 Yes | 2 000 |
| The state of Death of | /ita | cien: ertific ector, | Be | examiner? | 0.4 | 1123-2 | | |
| 1 State 1 | | Phys this a! di | \vdash | 1 Tes 2500 1 Inpatient 2 EH/Outpatient | 414 Nursing Home | / | | ufy) |
| 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 72 | | ing After une | ion | Tagatalar V in ording | Work? | 2. 2 030/100 //044 /// | lary occarros | |
| 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 72 | <u>S</u> | atl atl | lical | 3 Suicide 6 Could not be an Place of Injury At home form stor | | . Location (Street | and Number or Ru | ral Route Number, |
| 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 72 | Di≤ | lor A after Dire | ertii | 4 Homicide determined building, etc. (Specify) | , | City or Town, Sta | ate) | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thom from 301 ST. Foul Race # 701 Bankimore, MI) 21202. State 31. Date filed (Mohth, Day, Year) 32. Registrar's Signature | _ | spita hours nerel / fillec | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thom from 301 ST. Foul Race # 701 Bankimore, MI) 21202. State 31. Date filed (Mohth, Day, Year) 32. Registrar's Signature | | ne Ho n 24 h ne Fu | edic | | estigation, in my opinion, death occurred | at the time, date a | and place, and due | to the cause(s) |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thom from 301 ST. Foul Race # 701 Bankimore, MI) 21202. State 31. Date filed (Mohth, Day, Year) 32. Registrar's Signature | | To the within To the comp | | 0 | | | | |
| State 31. Date filed (Month, Day, Year) 32 Registrar's Signature |) | 1 | | Thankoon | 057088 | No | v. 24 | , 2006. |
| State 31. Date filed (Month, Day, Year) 32 Registrar's Signature | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, F | Print) H TO: R - OL | na.) | 3/303 | |
| Registrar NOV 2 9 2006 | | | | 31. Date filed (Month, Day, Year) 32 Registrar's Signature | TITUI LOWITIME | 4 /11/ | जाळाज. | |
| | | | | NOV 2 9 2006 1000 A 1900 | | | | |

| | | - | For State Registrar | State of I | Marylan | | artmer <i>rtifica</i> (| | | ind Me | | giene Reg. No | 2000 | 3 | 7839 |
|------------|---|----------------------|--|---|--|------------------|----------------------------|---------------------------|----------------------------|--------------------------|--|------------------|-------------------------------|--|-----------------------------------|
| | Physicia | | 1. Decedent's Name (First, Middle, La | | | | | | | | 2. Date of Dea Month | Da | | | ne of Death |
| | /Medic | al - | MARLENE 4a. Facility Name (If not institution, giv | | ar) | WAT | 1 | Town or | Location of | | OVEMB | | 26, 200 County of Dea | | 00 M |
| - | Examin | er | | | -"/ Haseit | 41 | | | MOLE | | 174 | | | | |
| | Funeral | | 5. Social Security Number 6. S | Sex 7. | | last birthday) | - | r 1 Year | If Under 2 Hours | | B. Date of Birt (Month, Day | h v. Year | 9. Bir | thplace (St | ate or Foreign |
| L | Director | | 213-34-0047 | 1□M 2 X 7F | 70 | Yrs. | NOTITIES | Days | Tiouis | | 1-16-1 | | | zland | |
| | and ** | - | Usual Residence of Decedent 10a, State 10b, County | | 10c. Cit | ty, Town or L | ocation | | | | | | | 10d. Insid | le City Limits |
| | f eho | ō | PA | | Shre | ewsbur | v | | | | | | | 1,🛛 | Yes 2 □ No |
| | r 28a | Director | 10e. Street and Number | | | | | p Code | | | | 10g. Cit | izen of What Co | ountry? | |
| | 23a o | a D | 17270 Mt. Airy Ro | ad | | | 173 | 61 | | | | USZ | A | | |
| | r dea | ner | 11. Marital Status | 12. Was Decede Armed Force | es? | .S. 13. | Was Dece If Yes, spe | dent of Hi | ispanic Orig n, Mexican | gin? (Spec , Puerto R | ify Yes or No- ican, etc.) | - | 14. Race - Ame Black, Whit | | n, |
| 36 | safte , or th | Y. | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 If Yes, Give Year or Date | | | 1 🗆 Yes | XXNo | Specify: | | | | Specify: Wh | ite | |
| 21215-0036 | P hour | edit | 15. Decedent's E | ducation | | | dent's Usu | | | | | 16b. K | ind of Business | /Industry | |
| 215 | hin 72 | plet | (Specify only highest gr. Elementary/Secondary (0-12) | ade completed) College (1-4) | or 5+) | (Give | DO NOT L | ork done d ise retired | during most () | of working | 7 | | | | |
| 7 | ed wit ygiene yer thu | Completed by Funeral | 12 | | | Homem | aker | | 40.14.1 | | | | wn Home | | |
| and I | be fill d oth | Be | 17. Father's Name (First, Middle, Last |) | | | | | | | First, Middle, e Helmo | | Sumame) | | |
| Maryland | hould d Mer mark matic | ဥ | John Cavey 19a. Informant's Name/Relationship (| (Tvoe. Print) | | 19b. Mail | ina Addres | s (Street a | | | | | or Town, State, | Zip Code) | |
| Ma | nd 2 s lith ar 27 is r trau | 1 | J. Leonard Watts | | | | • | | | | | | PA 173 | | |
| ē, | item item othe | | 20a. Method of Disposition | | | Place of Disp | osition (Na | me of | | Da | | | ocation - City or | | te |
| Ē | Page ment c | 1 | 1 ∏Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci | | " Gar | | | | | | | | timore, | | |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-f show enty follury or other traumatic event, I'm Medical Examinar must be notified at once. | | 21. Signature of Funeral Service Lice | | | | | | | | | | | | me, P.A. |
| | 40 F € Ø | | 23a. Part1. Enter the disease, or con | | noits | | | | | | | | TIMORE, | Approx | |
| | Pnysician /Medical Examiner | | shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | aAsp Due to (or | th line. URAT as a consecutive E | TION quence of): | | | NONIA | | | | | Onset | I Between and Death ALNUTES |
| 8760, | death certificate be executed e attending physicien and id for use as the burial-itransit | icai Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or | as a consec | quence of): | | | | | | | | | CHRO |
| .O. Box 68 | the death certific y the attending p ched for use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown | | h 2∐Feta ntattime of o | aldeath 3 | □Ectopic p □ Other (s | | | | | | 23d. Date of de Month | livery Day | Year |
| <u>α</u> | # B 8 | ٥ | Part II. Other significant conditions | contributing to deat | th but not res | sulting in the | underlying | cause give | en in Part I. | | | | use contribute t | | |
| I Records, | The law requires ate has been sign page 2 should be | Completed | | | | | | | | | | | prior to death? | utopsy find completion 2 \(\text{No.} | ings available i of cause of |
| Vital | Physician: this certific al director, | Be | 25. Was case referred to medical examiner? | Hospital: | | | | Oth | | | (Check only o | | | | |
| of | Phys. this cral dir | <u>۲</u> | 1 ☐ Yes 2 ☑ No 27. Manner of Death | 28a. Date of | | ER/Outpatie | | | | | e 5 Residente la R | | 6 □Other (Spe | ecify) | |
| | ding Ih. Th. Tuner | ţ | 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation | (Month, | Day Year) | Injury | M | 28c. Injun Work | k? Yes 2⊡i | | | | ., | | |
| Division | al or Attending s efter death. il Director: Afte | Certification: | 3 Suicide 6 Could not 4 Homicide determined | be 28e. Place of | f Injury - At h g, etc. <i>(Sp</i> ec | nome, farm, s | treet, facto | ry, office | | 21 | Bf. Location (City or To | | nd Number or F e) | ural Route | Number, |
| | To the Hospital or within 24 hours efter To the Funeral Director completely filled in E | Medical (| | hysician: To the baseminer: On the basemand manne | is of examin | | | | | | | | | | use(s) |
| | withir To 11 | Z | 29b. Signature and title of certifier | | | | | | e number | | | 29d. Da | ite signed (Mon | th, Day, Ye | ear) |
| | , T. | | Valor | | | DOCT | OP | RES | 5-00 | 0 | | Nov E | MBER : | 26, 2 | 006 |
| 1 |) | | 30. Name and address of person who | | | | | | | | | | | | |
| _ | St. | ate | THE JOHNS HOPKINS 31. Date filed (Month, Day, Year) | 32. | gistrar's Sign | ature | | | 1 84 | LTIM | LE N | MAKY | LAND 2 | 1205 | |
| | Regist | | NOV 2 9 2 | | | K | Land | , | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Year 08 520 AM É CORA WAINWRIGHT NOVEMBER 26 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HARBOR BALTIMORE HOSPITAL N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F 234 38 6827 79 1927 West Virginia Director 6, Usual Residence of Decedent the Maryland r 28e-f ehow 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2KING Directo Maryland Anne Arundel Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? me 23a or 613 Hammonds Lane U.S. 21225 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or iteme 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Specify: White 2 3 NWidowed 4 □ Divorced "nature!" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) W.R. Grace r then Elementary/Secondary (0-12) College (1-4or 5+) init. Pages 1 and 2 should be filed withing adment of Health and Mental Hygiene, ordent: if item 27 is marked other ther injury or other treumatic event, the Millury or other treumatic event, the Millury or other treumatic Factory Worker 12th Chemical Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Minnie Hash Bailey Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Wainwright / Son 3613 Saltwood Glen Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/28/2006 Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Department of the partment of 4001 Ritchie Highway Baltimore, Maryland 21225 anna 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** KESPIRATORY DISTRESS 1 week /Medical Due to (or as a consequence of) Examiner PULMONARY EMBOLISM 4 CUTE Linear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed HOVANCED LUNG, CANCER week that initiated events resulting in death) Last Due to (or as a consequence of): physicien er s the burial-t Box 68760. Physician/Medical attending p use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 1 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 3 Probably 4 □Unknown should b WITH RAPID VENTRICULAR 1 ☐ Yes 2 ☐ No. Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an DIFFICILE autopsy performed page certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA Si C 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours aff To the Funerel Di completely filled in Hospite 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD ale RES 001 NOVEMBER 26, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEJAL PATEL 3001 SOUTH HANOVER STREET BALTIMORE, MD 21225 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37841 For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** Brenda D. Williamson 8:48 p Nov 14, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1914 Woodbourne Avenue **Baltimore** N/A If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 € F Director 220-64-1140 50 Feb 1, 1956 Maryland Usual Residence of Decedent daath with the Maryland 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23s or 28s-f abow other traumatic avent, the Modical Examinar must be notified at 1 ¥ Yes 2 □ No Director Maryland N/A **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1914 Woodbourne Avenue 21239 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be fliad within 72 hours aftar-nant of Haalth and Mantal Hygiana. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: <u>^</u> Specify 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mercy Medical Center Tele-Communicationator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eddie Cherry **Dorothy Thames** ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) parmit. Pages 1 and 2: Dapartment of Haalth a Important: if item 27 is any injury or other trausonce. James A. Williamson Husband 1914 Woodbourne Avenue Baltimore, Maryland 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/22/06 4 □ Donation 5 □ Other (Specify) Garrison Forest Veterans Cemetery Owings Mills, Md. 21. Signature of Funeral Service Licensi 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 path. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the dishock, or heartfailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Terminal Acquired Immune Defiency Syndrome /Medical Due to (or as a consequence of) Examiner Esophageal Candidiasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed **burial-transit** the attanding physician and Severe Anemia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Asthma Physician/Medical tha IF FEMALE: 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) datachad 9 Unknown signad by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should ba Wasting Syndrome 1 Tes 2 No 3 Probably 4 Unknown baen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dehydration this certificata has autopsy performed? Yes 2 No 1 Yes 2 No. 1 Yes funaral diractor 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 🖔 Residence 6 ☐ Other (Specify) 2 ER/Outpatient Medical Certification: To 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Aftar 1 Natural 5 Pending within 24 hours area ...
To the Funeral Director: Atr 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 1/2001

Q

State

of death (Item 23a) (Type, Prin

who completed cause

Carlos

31. Date filed (Month, Day, Year)

| | | | 1 - State of Ma Registrar | | partment of Health and Nertificate of Death | Mental Hygien Rag. N | 211116 3 / 867 |
|---------------------|--|----------------|--|------------------------|--|--|---|
| | Physicia /Medic | | 1. Decedent's Name (First, Middle, Last) ARY WARD | | | 2. Date of Death Month Z | Vear South |
| | Examin | er | 4a. Facility Name (If not institution, give street and number) HOS PL TAL 5. Social Security Number 6. Sex 7. Age | (In yrs. last birthday | 4b. City, Town, or Location of Death 5 4 10 2 5 If Under 1 Year If Under 24 Hrs. | 8. Date of Birth | kc. County of Death N/A 9. Birthplace (State or Foreign |
| | Funeral Director | | 216-20-9579 Usual Residence of Decedent | 79 Yrs. | Months Days Hours Min. | 07717 /1927 | maryland |
| | a-f show | ctor | 10a. State Maryland N/A | 10c. City, Town or L | Baltimore | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| | 23a or 28 | rai Director | 10e. Street and Number 3013 RoseTawn Avenue | | 10f. Zip Code 21214 | 10g. C | Citizen of What Country? U.S.A. |
| 036 | al', or items | by Funerai | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes, 2 Married It Yes, Give Year or Dates: | | Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify: | pecify Yes or No- po Rican, etc.) | 14. Race - American Indian, Black, White, etc. Specify: White |
| Maryland 21215-0036 | should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23s or 28s-f show imatic event, it a Madical Exart or must be exittled at | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-1) | (Give | edent's Usual Occupation e kind of work done during most of won DO NOT use retired) PIOlogist | king | Kind of Business/Industry Itimore City |
| land : | | To Be C | 17. Father's Name (First, Middle, Last) John Davis Kilduff | | 18. Mother's Nam Mary Ri | ne (First, Middle, Maide tZ | en Sumame) |
| , Mary | d 2 stran | | 19a. Informant's Name/Relationship (<i>Type, Print</i>) Edward T. Ward - Husband | 3013 | ling Address <i>(Street and Number or Ru</i> B Roselawn Avenue Balt | imore, Maryla | and 21214 |
| altimore, | Page: nent o ant: If ury or | | 20a. Method of Disposition 1 🕱 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Garrison Fo | orest VA Cemetery 12/07 | 7/2006 Owi | ings Mills, Maryland |
| Bai | permit. Departr Importa eny Inje | | 21. Signature of Funeral Service Licensee Charles Mi | L | | 5305 Harford Baltinore, Ma | aryland 21214 |
| Ĭ | Pnysician /Medical Examiner | | 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line immediate Cause (Final disease or condition resulting in death) Due to (or as a | the death. Do not ene. | the mode of dying, such as cardiac | or respiratory arrest, | Approximate Interval Between Onset and Death |
| 8760, | | dical Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events c. | a consequence of): | | | |
| O. Box 6 | ath certific ittending p or use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown 23c. If yes, outcome of the past 12 months? 4 □ Pregnant at the past 12 months 20 □ Unknown | 2 Fetal death 3 | □Ectopic pregnancy □ Other (specify) | | 23d. Date of delivery Month Day Year |
| rds, P | quires that the de in signed by the a uld be detached f | | Part II. Other significant conditions contributing to death bu | t not resulting in the | underlying cause given in Part I. | | o use contribute to the cause of death? 2 🗆 No 3 🗆 Probably 4 🗗 Unknown |
| Vital Records, | i: The law require icete hes been siç r, page 2 should b | Completed by | plmonsey hyperta | ~5/0~ | | 24a. Was an autopsy performed? | |
| Division of Vita | l or Attending Physicien: The lavalter death. Director: After this certificete hes in by the funeral director, page 2 | ation; To Be | 25. Was case referred to medical examiner? 1 | | ent 3 DOA Other: 4 Nursing H | th (Check only one) ome 5 Residence 28d. Describe how in | |
| DIVIS | itel or Attendii is after death. ral Director: Al led in by the fu | Certification; | 4 Homicide Statistics building, etc. | | | City or Town, Sta | |
| | To the Hospitel or A within 24 hours after To the Funeral Direcompletely filled in by | Medical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner state 29b. Signature and title of certifier | examination and/or it | ath occurred at the time, date and place investigation, in my opinion, death occur | rred at the time, date a | (s) and manner as stated. Indiplace, and due to the cause(s) Date signed (Month, Day, Year) |
| | 10 | | Jog Costa, NI |) | 1) 4126 | 34 N | N 28 2006 |
| N | \U Sta | ite | 30. Name and address in person who completed cause of de | ar's Signature | ST. PAUL PLA | ~E BA | UNDERE MOZIZOZ |
| 4 | Registr | | NOV 2 9 2006 Distur | 1 N. 18 | article . | | |

06-08956 Gary Williams

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

| | 1- For State Registrar Registrar | 3784 |
|--|--|--|
| Physician Medical Examine | 7 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year | Time of Death |
| neuicai Examine | Gary Williams November 24, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death | 10401113 |
| 1 | 1227 Steelton Ave Apt 2 Baltimore N/A | |
| Funeral Director | 5. Social Security Number 2.15-74-2031 1X M 2 F 48 Yrs. If Under 1 Year If Under 24Hrs. If Und | olace (State or o ^{try)} Maryland |
| ' any | 10a. State 10b. County 10c. City, Town or Location | 0d. Inside City Limits |
| Aaryland 28a-f show 1 at once. | Maryland N/A Baltimore | 1XX Yes 2 No |
| eath with the Maryland items 23a or 28a-f shoust be notified at once. | Maryland N/A Baltimore 10e. Street and Number 1227 Steelton Avenue 10f. Zip Code 10g. Citizen of What Country 21224 United State | es |
| within 72 hours after death with the Maryland within 72 hours after death with the Maryland her than "natural", or items 23a or 28a-f she "Medical Examiner must be notified at once more than 15 hard to 15 hard | 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American White, etc. | |
| rs after ural", miner | 342 Widowed 4 Divorced II Yes 24 No specify: Specify: Specify: Specify: 1 Yes 24 No specify: Specify: Specify: 1 Specify: Specify: Specify: Specify: 150 Decedents Education (Specify done 15th Kind of Business/Inc.) | White |
| 72 hou n "nat al Exa | Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired) | |
| 5-0036 led within 72 hours after dygiene. other than "natural", the Medical Examiner | Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor of Assembly Line Manufactur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) | ing |
| [유료공료체 C | 17. Father's Name (First, Middle, Last) George Washington Williams 18. Mother's Name (First, Middle, Maiden Surname) Lillian Milligan | |
| imore, MD 2121! Pages I and 2 should be fill ment of Health and Mental I inter T item 27 is marked or other training event, | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 | Zip Code) LO34 |
| Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and In Important: If item 27 is in injury or other traumatic | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or T | own, State |
| Baltimore, permit. Pages 1 ar Department of He Important: If ite Important: If ite Injury or other tr | 4 Donation 5 Other Specify: Hilltop Service Corp. 11/28/2006 Towson. | Marvland |
| Ball permit Depart Impor | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility udda—Ruck Funeral Home of Dundalk, Inc. 7022 Name and Address of Facility | 222 |
| Physician | 23a. Part I. Enj. the dise, se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. If to the such cause on each line. | Approximate Interval Between Onset and |
| /Medical | Immediate Cause (Final disease a. Hypertensive atherosclerotic cardiovascular disease | Death |
| | or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b. | |
| | If any, leading to immediate Oue to (or as a consequence of): | |
| uted uted ransit | If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d. | |
| 760, cate be executed physician and the burial - transit | UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery | |
| Box 68760, c death certificate by the attending physic of for use as the bur | 2 25b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Definition of 5 Other (Specify) | ıy Year |
| that the dea red by the a | Yes 2 No 9 Unknown 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the contribution of the contri | ne cause of death? |
| i, P.C ires that signed to be deta | | bly 4 🗸 Unknown |
| w requir | | psy findings available mpletion of cause of |
| Recc The lav | performed? 1 Yes 2 № N 1 Yes | 2 No |
| Vital Recysician: The linis certificate director, page | 25. Was case referred to medical 26. Mace of Death (Check only one) When the spiral is a spiral control of the spiral control of th | Cana |
| ing Physical differential di | O 1 Yes 2 No 1 Imparent 2 Endoutpatient 5 DON 4 Not sing from 5 Treatment 6 Works. 28d Describe how injury occurred | Scene |
| ion (tendin leath. A the fur | 1 V Natural 5 Pending 2 Accident Investigation | |
| Division of Vital Records, P.O. spital or Attending Physician: The law requires that to ours after death. The law requires that the rest Director. After this certificate has been signed by filled in by the funeral director, page 2 should be detained in the filled in by the funeral director. | The state of Death State of Injury - At home, farm, street, factory, office building, etc. 1 | al Route Number, City |
| | To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the | |
| To Kiri | and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Monte | h, Day, Year) |
| | CC-: November 27, 200 | 06 |
| 3 | 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 | |
| Star Registra | MICH Z. M. MILLE ENGINEER AND AND AND AND AND AND AND AND AND AND | |

STRLL

3. Time of Death

6:05 P M

| 1 | - | For State |
|---|---|--------------|
| | - | Registrar |

1. Decedent's Name (First, Middle, Last)

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death

|) | J | L | 0 | 1 |
|---|---|---|---|-------|
| | | | | |

9. Birthplace (State or Foreign

10d. Inside City Limits 1 ☐ Yes 2 🔀 No

| - 1 | | | Decedent's Name | e (First, Middle | , Last) | | | | | | | | 2. Date of E Month | Death | Dav | Year | 3. Time of Deat | |
|------------|--|---------------------|---|--|--------------------------------------|--------------------|-----------|------------------------------|---|----------------|---------------------|-----------------|-----------------------|---------|---------------|--|---------------------------------|--|
| _ | Physici /Medic | | Beatrice | V. Whee | eler | | | | | | | | Nover | nber | 24, | 2006 | 6:05 P | |
|) | Examin | | 4a. Facility Name (I | If not institution, | give street and nu | ımber) | | | 4b. City, | Town, or | Location | of Death | | | 4c. Count | y of Death | | |
| | | | 1013 Dow | vnton Ro | 1 | | | | Hale | thor | ре | | | | В | altim | ore | |
| | Funeral | | 5. Social Security N | lumber | 6. Sex | 7. Ag | . , | last birthday | If Under | 1 Year Days | If Under | 24 Hrs. Min. | 8. Date of E | | ear) | 9. Birth | place (State or Fore | |
| | Director | | 213-28-94 | 488 | 1 □ M 2KD F | | 75 | Yrs. | Wiotigia | Days | 110013 | TVINI. | 11/27 | 7193 | 30 | Mary | ľánd | |
| | ס | | Usual Residence of | | | | | | | | | | | | | | | |
| | ehow | | 10a. State | 10b. County | | | 10c. City | y, Town or L | ocation | | | | | | | | 10d. Inside City Lim | |
| | the Maryla 28a-f ehor | ţō | MD | Baltin | nore | | Ha1 | ethorp | e | | | | | | | | 1 🗋 Yes 2 🔯 | |
| | r 28a | rec | 10e. Street and Nur | mber | | | | | 10f. Zip | Code | | | | 10g. | Citizen of | What Cou | ntry? | |
| | th with | aiD | 1013 Dow | nton Rd | | | | | 2 | 1227 | | | | Un | United States | | | |
| 920 | with 72 hours after death with the Maryland ene. than "natural", or itema 23e or 28e-1 ehow he Medical Examiner must be notilled at | by Funeral Director | | | | | | | If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | | | | | | Bla | 4. Race - American Indian, Black, White, etc. Specify: White | | |
| 2-0 | "natur | eted | (Spec | (Specify only highest grade completed) | | | | 16a. Dece | dent's Usu s kind of wo | al Occupa | ation during mos | st of work | ung | 16t | o. Kind of E | Business/In | dustry | |
| 21215-0036 | e filed within Il Hygiene. other than ' | Completed | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) Beautician | | | | | | | | Cosmeto | | | | tolog | зу | | |
| g | at the | a | 17. Father's Name | (First, Middle, I | .ast) | | | | | | 18. Moth | er's Nam | e (First, Midd | le, Mai | den Suma | me) | | |
| Maryland | D 2 0 0 | To B | William | Lawrenc | e Charle | S | | | Leila May Catterton | | | | | | | | | |
| ary | 12 should h and Men 7 is marke treumatic | | 19a. Informant's Na | ame/Relationsh | ip (Type, Print) | | | 19b. Mail | ing Address | (Street a | and Numb | er or Rui | al Route Num | ber, C | ity or Town | n, State, Zip | Code) | |
| | Ð # !: ₽ | | Debbie L | ober / | daughter | | | 1013 | Down | ton 1 | Rd Ha | leth | orpe, | Mar | yland | 1 2122 | 27 | |
| ē, | S - = 0 | | 20a. Method of Disp | • | | | 20b. P | tace of Disp emetery, cre | osition (Na | ne of | e) | | Date | 200 | . Location | - City or To | own, State | |
| Baltimore, | | | 1 🔯 Burial 2 4 □ Domation | | 3 □Removal from pecify) | State | 1 | dlawn | | | | 11/2 | 8/2006 | Wo | odlaw | vn, Ma | aryland | |
| at | permit. Pag Department Important: I eny injury c | | 21. Signature of Fu | neral Service L | icersee | | ~\ 1 | 2 | 2. Name ar | nd Addres | s of Facili | ty Amb | rose F | 'une | ral H | Home, | Inc. | |
| _ | 40F 99 | | Julu | AL F | XILIE | L | M | 1 | 328 S | u1ph | ur Sp | ring | Rd Ar | but | us, M | iary1a | and 21227 | |
| | | | 23a. Part1. Enter to shock, or hea | he disease, or art failure. List of | complications that only one cause on | caused each lir | the leath | n. Do not en | ter the mod | le of dyin | g, such as | cardiac | or respiratory | arrest, | | | Approximate Interval Between | |
| | Physician | 9 1 | tmmediate Cause disease or condition resulting in death) | | _a | Ur | 26 | CF | NIC | En | | | | | | | Conset and Death | |
| | /Medical | | resulting in death) | | | | | 45 | | | | | | | | | | |

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

/Medical Examiner

Examine ettending physician and for use as the buriat-transit use as the

signed by the e page 2

Physician/Medical δ Completed Be မ

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifice completely filled in by the funeral director, f. Certification: Medical

peeu

certificete

Division of Vital Records, P.O. Box 68760,

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury

that initiated events resulting in death) Last

23c. If yes, outcome of pregnancy

4□Pregnant at time of death 9□ Unknown

3 DEctopic pregnancy 5 Other (specify)

2. Date of Death

Day

Approximate Interval Between Onset and Death SHTWOM =

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 2 🗌 No

23d. Date of delivery

3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 2/2 26. Place of Death (Check only one)

Yes

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 21200 1 🗌 Yes 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Natural

and manner stated

5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1st Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

00040012

1 ☐ Yes 2 ☐ No

NOVEMBER 27, 2006

erson who completed cause of death (Item 23a) (Type, Print) 30. Name and add 405 FREDERICK ROD, SUITE DOY, CATONSVILLE, MP 31228 YOULTON

2006

31. Date filed (Month, Day, Year)

NOV 2 9

29b. Signature and title of celtifier

29a. Certifier

State Registrar

| | | | 1 - For State Registrar | State of | Marylar | - | artmen <i>rtificat</i> | | | | ental Hy | giene Reg. No. | 006 | 37 | 845 |
|-----------|--|---------------------|---|---|----------------------------------|--------------------------------|--|--------------------------------|------------------------------------|--------------------------|--|--------------------------|--|--|----------------------|
| | Physici | | 1. Decedent's Name (First, Middle, La Marion E. Will | • | | | | | | | 2. Date of Do Month | Day 25 | 2006 | 3. Time of 2:50 | |
| | /Medio Examir | | 4a. Facility Name (If not institution, given SALNT AGNES | | | • | 4b. City, BA | Town, or | Location o | of Death | 1000 | | unty of Death | | |
| | Funeral Director | | 219-01-5480 | Sex 7 1 □ M 2 🖾 F | | last birthday) 87 Yrs. | If Under Months | 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bi (Month, D) Jan . 1 | rth 2, 1919 | 9. Birthpl Coun Mary | ace (State of Iand | or Foreign |
| | e Maryland | ctor | Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo | re | 10c. Ci | ty, Town or Lo | cation nsvil | 1e | | | | | 10 | 0d. Inside C | ity Limits 2∑No |
| | 3a or 26 | i Directo | 10e. Street and Number 5743 Edmondson A | venue | | | 10f. Zip | Code 1228 | | | · | • | of What Coun | ry? | |
| 036 | should be filed within 72 hours efter deeth with the Maryland of Mental Hygiene. marked other than "natural", or iteme 23a or 28a-f ehow matte event, Ita Medical Exercities treat be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced | 12. Was Deced Armed Forc 1 Yes 2 If Yes, Give Year or Date | es? X | | Was Deced | lent of His | spanic Origin, Mexican Specify: | gin? (Spe i, Puerto l | cify Yes or Ne Rican, etc.) | 0- 14. | Race - America Black, White, e ecify: Whit | tc. | |
| 1215- | i within 72 ho ilene. r than "natur the Medical | Completed | 15. Decedent's E (Specify onfy highest gr Elementary/Secondary (0-12) | ducation ade completed) College (1-4 | or 5+) | life. I | lent's Usua kind of wor DO NOT us Secre | rk done d se retired) | uring most | t of workin | ng | | of Business/Ind | , | |
| yland 2 | should be filed and Mental Hygis marked other umatic event, III | To Be C | 17. Father's Name (First, Middle, Last Henry H. Watts | | | | | | Mary | Galw | | , Maiden Sui | mame) | | |
| | 1 end 2 s Heelth ar am 27 le | | 19a. Informant's Name/Relationship (Richard Crawford 20a. Method of Disposition | ,, , | Son 20b. F | | Harle | quin | | ; Se | | Park, | own, State, Zip Marylar ion - City or Tox | nd 211 | .46 |
| altimore, | Z if e | | 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Funeral Service Lices) | fy) | ate | cemetery, crem dowrid | natory'or of ge Me | m. P | ark 1 | 1/29 | /2006 | E1kri | dge, Ma | rylan | |
| Ba | permit. Depertm fmportar eny inju | | Deman | Delve | solei | 7 | Funer 1630 | al H Edmo | ome ondsor | of Ca | tongvi | ile,In atonsv | Schwab ic. ille, N | mitzk 1D 212 | .e 228 |
| | Physician / Medical Examiner Physician | Examiner | 23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last | a. Due to (or Due to . | th line. | Projuence of): TE Gruence of): | VEU | M | oNi | A | | | | Approximation of the conservation of the conse | ween Death |
| | the death certific y the ettending p sched for use es | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 4□Pregnan 9□Unknow | n 2∐Feta it at time of d n | ldeath 3 leath 5 | Ectopic pre | ecify) | | | | 23d. | Date of deliver Month | | Year |
| Hecords, | The law requires thet ste hes been signed b sege 2 should be dete | þ | Part II. Other significant conditions of | contributing to deat | h but not res | ulting in the ur | derlying ca | ause give | n in Part I. | | _ | obacco use o Yes 2□N | contribute to the | | leath? Jnknown |
| | | e Completed | 25. Was case referred to medical | | | | | | | | 1 ☐ Yes | osy ormed? 2.00 No | 4b. Were autop prior to com death? 1 Yes | sy findings a pletion of ca ! \(\text{No} \) | available ause of |
| ö | Physici this cer al direc | Certification; To B | examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b | n | Injury Day Year) | 28b. Time of Injury | M 28 | A Other Bc. Injury Work 1 Y | 4 □ Nur | rsing Hom | 8d. Describe | dence 6 D | | | |
| 20 | To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funer | | 4 Homicide determined | building | etc. (Specif | wledge death | occurred a | at the time | e, date and | 1 place as | City or To | wn, State) | umber or Rural | lad | |
|) | To the Hospital within 24 hours of To the Funeral completely filled | Medical | (Check only 2 Medical Example) 29b. Signature and title of certifier | niner: On the basi | s or examina | tion and/or inv | estigation, | I icense | nion, deat | h occurre | d at the time, | date and pla | ce, and due to | he cause(s) | |
| | 3 | | 30. Name and address of person who Privarian (Month Pay, Year) | Des | of death (Item | ND. 9 | Print) | CATO | 0N | NE | E, BA | LTIMO | 25 ORE N | 1D 21 | 1229 |
| , | Sta Registr | | NOV 2. 9. 200 | | | Mark | 2.0 | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 26, 2006 Physician November 5:15 PM GEORGE PAGE WEST, JR. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Healthcare Center Towson Baltimore County Blakehurst If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 9, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1₩ 2□F Months 89 219-01-4040 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Directo Maryland Baltimore County Towson 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1055 West Joppa Road 21204 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No WW I If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: Specify: White Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineering Sales Tool Manufacturing 4 Ith and Mental Hygie 27 is marked other ther the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Page West, Sr. Swindell 2 Mildred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is any injury or other traionce. 3109 Allerton Lake Drive,, Winston-Salem, NC 27106 G. Page West, III (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 11/30/2006 Pikesville, Maryland Druid Ridge Cemetery 21. Sign We of Emperal Served Ly see

Martin D. Lawson 22. Name and Address of Facility Jawson Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Alzhermers Deventis Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the buriel-trensit or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) 23b. Did tobecco use contribute to the cause of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 □ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ð 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation s efter dea.. •ai Director: Afte 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be determined within 24 hours efter dex To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Dayé signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) III, M.D., 6301 North Charles Street, Baltimore, MD 21212 Inlehart, Iredell W. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

| | | | 1 - For State Registrar | State of Maryla | | artment rtificate | | | nd M | ental Hy | gien Reg. N | 4 U L | 6 | 37847 |
|----------------------------|--|-------------------|---|---|--|--|-------------------------|--|-----------------------|--------------------------------------|------------------------|------------------|--------------------------------|--|
| | Physici | an | 1. Decedent's Name (First, Middle, Last | ZANTT | | | | | | 2. Date of D Month | Da | | Year | 3. Time of Death |
| | /Medi Examir | cal | 4a. Facility Name (If not institution, give | | | 4b. City. To | own or | Location of | Death | Nover | | このunty | 2006 | 04:38PM |
| | EXAIIII | iei | HARBOR HOSPIT | | | , | | MOR | | N/A | | | | |
| | Funeral Director | | 5. Social Security Number 6. Se 214 44 3637 | 7. Age (In yrs | s. last birthday) Yrs. | If Under 1 Months | Year Days | If Under 2 Hours | Min. | 8. Date of B (Month, D Nov . 2 | irth ay, Year | 939 | Coun | lace (State or Foreign try) land |
| | pug * | | Usual Residence of Decedent 10a. State 10b. County | 100.0 | ity, Town or Lo | ncation | | | | | | | | 04 1-14-01-11-11- |
| | Maryla | ō | Maryland N/A | | Baltimo | | | | | | | | , , | 0d. Inside City Limits 1 Yes 2 No |
| | r 28a | Directo | 10e. Street and Number | <u> </u> | Darcino | 10f. Zip C | ode | | | | 10g. C | itizen of V | Vhat Coun | itry? |
| | th with | a D | 1518 Plum Stree | et | | | 212 | 26 | | | | U.S. | | |
| 920 | n 72 hours after death with the Maryland "naturel", or iteme 23a or 28a-f show adical Examinar must be notified at | by Funeral | 11. Marital Status 1 Never Married 2 Narried 3 Widowed 4 Divorced | 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | | Was Deceder f Yes, specific 1 Tes 2 | | spanic Orig n, Mexican, Specify: | in? (Sper Puerto F | cify Yes or N lican, etc.) | 0- | Blac | e - Americ k, White, Bla | etc. |
| 50 | 72 hc | eted | 15. Decedent's Edu (Specify only highest grad | ucation le completed) | 16a. Deced | dent's Usual kind of work DO NOT use | Occupa done di | tion uring most | of workin | a | 16b. F | (ind of Bu | siness/Ind | lustry |
| 21215-0036 | filed within 'I Hygiene. other than "rent, the Mer | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | | maker | retired) | | | | | Own | Home | |
| /land | d be well a be with a bear a b | To Be | 17. Father's Name (First, Middle, Last) Basil | Jones | | | | | | (First, Middle Sprig | | <i>Suma</i> m | Θ) | |
| Baltimore, Maryland | and 2 shou ealth and M n 27 is mar her traumati | | 19a. Informant's Name/Relationship (7) Grace Zantt / Dat | ughter | 1518 | Plum S | Stre | | | Route Numb timore | | | | |
| imore | permit. Pages 1 and Department of Heall Important: if Item 2 any Injury or other once. | | 20a. Method of Disposition 1 | Removal from State | Place of Dispo cemetery, cren edar Hi | 11 Cem | <i>er place</i> eter | ry 1 | 1/27 | /2006 | Ba1 | timo | - | Maryland |
| Balt | Depertiment Import | | 21. Signature of funeral Service Licens | Ildridg | 401 | Name and . 001 Ri | | | Go: ghwa | nce Fu y Bal | nera timo | 1 Se re, | rvice Mary1 | e, P.A. and 21225 |
| 8760, | Physician / Medical Examiner but in physician and physician and the pruial-transil | ai Examiner | 23a. Part1. Enter the disease, or compleshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Respirator Due to (or as a consection) Due to (or as a consection) | quence of): -chro quence of): Stoint quence of): | e-Billi nic l estina | rena R1 | el ma alfai blæd | lure | ant el - Mul | fusi | | mols | Approximate Interval Between Onset and Death 3-4 Welk 9 3-4 Welk 1 Week 1 Week |
| P.O. Box 687 | The law requires that the death certificate be executed at the has been signed by the attending physician and asge 2 should be detached for use as the burial-transit | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown | 23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown | ancy al death 3 | Ectopic preg | nancy | | | | | 23d. Date Mon | of deliver | y Day Year |
| rds, P | w requires that been signed b should be deta | þ | Part II. Other significant conditions con Endome VISI | ntributing to death but not re | sulting in the un | derlying caus | se giver | n in Part I. | | 23e. Did 1 | | . 1 | | e cause of death? |
| Division of Vital Records, | The law re ate has bee page 2 sho | Completed | | | | | | | _ | 24a. Was auto perio 1 Yes | | p | rior to com eath? | sy findings available apletion of cause of |
| /ita | ician: Th certificate rector, pag | Be | 25. Was case referred to medical examiner? | | 1877 | | T . | | f Death | Check only | - | | | 7 |
| of | Phys this ral dir | 2 | 1 Yes 25 No 27. Manner of Death | | ER/Outpatien | | Other | 4 🗆 Nurs | | e 5 ☐ Resi | | | |) |
| o | ding Ith. : After funer | tlon | 1 ▲ Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day Year) | Injury | M 280 | . Injury a Work? | at es 2⊡No | i | ld. Describe | now inju | ry occurre | ed | |
| Divisi | al or Attender after death of the control of the co | Certification; | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At h building, etc. (Special | nome, farm, stre fy) | | | | | If. Location (City or To | Street an wn, State | d Numbe | r or Rural | Route Number, |
| | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page | edicai C | 29a. Certifying Physical Control (Check only one) | sician: To the best of my kn ner: On the basis of examin- and manner stated. | owledge, death ation and/or inv | occurred at lestigation, in | the time | , date and nion, death | place, ar occurred | d due to the at the time, | cause(s) | and mar | ner as sta | ited. the cause(s) |
| | To the H within 24 To the F complete | Ň | 29b. Signature and title of certifier | | | | icense r | number | | | | | (Month, D | |
| | 5 | | 30. Name and address of person who co | | m 23a) (Type, I | Print) | | | ANX | NER | | | . 3 | 1 4000, |
| İ | Sta Registr | | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | | | | | | | J | * | | |
| DH | MH 17 Rev 1/20 | 001 | NOV Z 9 ZC | NO PORTO | | | | | | | | | | |

ORIGINAL

| | | | 1 - For State Registrar | State | of Mary | land / Dep <i>Ce</i> | | ent of H | | | ental Hy | giene | 006 | 378 | 48 |
|---------------------|--|---------------|---|----------------------|--|--|-------------------------|-------------------------------|-----------------------------|----------------------------|---------------------------------------|-----------------------------|-----------------------------|---|--------------------|
| | Physici | ian | Decedent's Name (First, Midd | | | | | | | } | 2. Date of Do | eath Day | Year | 3, Time of | |
| | /Medi Examir | | Horacio Aguirre 4a. Facility Name (If not institution | | f number) | | 4b. Ci | ty, Town, or | Location | | Novemb | | 2006 ounty of Dea | 0227 | М |
| | LAdillii | iei | Howard County | | | al | | lumb i a | | | | | ard | | |
| | Funeral | П | 5. Social Security Number | 6. Sex 1 ፟፟ M 2 ☐ | 7. Age (In | yrs. last birthday |) If Und | der 1 Year | If Under Hours | Min. | B. Date of Bi (Month, D | av. Year) | 9. Bir | thplace (State or ountry) | r Foreign |
| | Director | | 581-94-7855 Usual Residence of Decedent | 123 (11) 2(3) | | 71 Yrs. | | | | F | eb 27, | 1935 | Arg | gentina | |
| | yland | | 10a. State 10b. County | · | 100 | c. City, Town or L | ocation | | | | | | | 10d. Inside Cit | y Limits |
| | 8a-fel | ctor | MD Howar | d | E | llicott (| City | | | | | | | 1 ☐ Yes | 2 X No |
| | vith th | Director | 10e. Street and Number | | | | | Zip Code | | | | 10g. Citize | n of What C | ountry? | |
| | eath v | Funeral | 3572 Mt. Ida D: | | Decedent Ever | in 11 S 12 | 210 | | anania Osi | nin2 (Cnani | 4. Va N | USA | Dana Am | | |
| 36 | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or iteme 23a or 28a-1 show aumatic event, the Madical Examinar must be notified at | by Fun | 1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorced | ried 1 TY | d Forces? es 2∭∑No , Give | 13. | | 2 No | Specify: | | ify Yes or No ican, etc.) | | Black, Whi | | |
| Maryland 21215-0036 | 2 hour | ted t | 15. Deceder | nt's Education | or Dates: | 16a. Dece | dent's Us | sual Occupa | ation | Argen | | | of Business | | |
| 215 | thin 7. | Completed | (Specify only higher Elementary/Secondary (0-12) | | ed) ge (1-4or 5+) | (Give | kind of v DO NOT | work done d use retired | turing most) | t of working | 7 | | 01 040111034 | and day | |
| 2 | ygien ygien ygien yer th | Con | 7 | | , | Traine | er | | | | | Raceh | | | |
| and E | ntal H | Be | 17. Father's Name (First, Middle, | , | | | | | | | First, Middle | | ımame) | | |
| Ž | should nd Mei mark matic | င္ | Fernando Santo 19a. Informant's Name/Relations | | | 19h Maili | na Addre | | | | alinas | | own, State, . | Zio Co da l | |
| <u>S</u> | nd 2 salth ar 27 io | | Anthony Aguirr | | | | | | | | , MD 2 | | own, State, i | zip Code) | |
| Ž. | es 1 a of Hei of Hei r othe | | 20a. Method of Disposition | 2 CD | | 0b. Place of Dispo | osition (N | iame of | 9) | Dat | te | 20c. Loca | tion - City or | Town, State | |
| Ĕ | ment ment ant: f | | 1 ☐ Burial 2 🏹 Cremation 4 ☐ Donation 5 ☐ Other (S | Specify) | om State | Chesapeal | | | · 1 | 11/10 | /06 | Belts | ville, | MD | |
| Baltimore, | permit. Pages 1 and 2 should be Deperment of Health and Menta Important: If Item 27 Ie marked any injury or other traumatic expose. | | 21. Signature of Funeral Service | Licensee | # | GG 401251 Be | | | | | | | .O. Bo | | 1000 |
| ł | Physician /Medical Examiner | er | 23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | a. Cer Due | ebral V to (or as a cor | death. Do not en /ascular nsequence of): | ter the m | ode of dying |), such as | cardiac or r | espiratory a | rrest, | | Approximate Interval Betw Onset and D | reen |
| 68/60, | the death certificate be executed y the attending physician and ched for use as the burial-transit | edicai Examin | causes. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c Due | to (or as a cor | nsequence of): | | | | | | | | | |
| O. BOX | that the death certificated by the attending point of the detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1□Lin 4□Pr | outcome of prove birth 2 egnant at time or the common common contract time or the common com | Fetal death 3 | ∄Ectopic ∄Other (| pregnancy specify) | | | | 230 | I. Date of del Month | , | ear . |
| ro, | requires that een signed b | by Pf | Part II. Other significant condition | ons contributing t | o death but no | t resulting in the u | nderlying | cause give | n in Part I. | | 23e. Did t | obacco use | contribute to | the cause of de | ath? |
| cords, | w require been signatured should t | ted | | | | | | | | ' | 10 | Yes 2.□X | No 3∏Pr | obably 4 □Ur | nknown |
| Ľ | he law hes b | Completed | | | | | | | | | 24a. Was autop perfo 1 🗆 Yes | osy ormed? | th. Were au prior to death? | itopsy findings a completion of car | variable use of |
| Vital | Physician: Th this certificate ral director, pag | Be (| 25. Was case referred to medica examiner? | | | | | | | | Check only o | one) | | | |
| 5 | Phys this aldi | ٦. | 1 ☐ Yes 2 📉 No 27. Manner of Death | | | 2 ER/Outpatier | | OA Othe | ^C 4 □ Nur | | | | Other (Spec | cify) | |
| | ding After fune | tlon | 1 Natural 5 Pendir 2 Accident investi | | ate of Injury fonth, Day Yea | 28b. Time o Injury | м | 28c. Injury Work 1 □ Y | at ? es 2 □ N | | d. Describe i | now injury o | ccurred | | |
| DIVISION | after death after death Director: | ertification: | 3 Suicide 6 Could 4 Homicide determ | not be 28e. PI | ace of Injury - , uilding, etc. (Sp | At home, farm, stroecify) | | | | | Location (S City or To | | lumber or Ru | iral Route Numb | Θ <i>Γ</i> , |
| | To the Hospitat or Attent within 24 hours after death To the Funeral Director: completely filled in by the | edical C | 29a. Certifier 1X Certifyir (Check only one) | examiner: On th | the best of my e basis of exar anner stated. | knowledge deall mination and/or in | l occurre vestigatio | d at the tint on, in my op | e, date and inion, deatl | f place, and h occurred | dus to the at the time, | dause(s) an date and pla | d Tanner as ace, and due | stated, to the cause(s) | |
| | To th within To the | Me | 29b. Signature and title of certifie | | | | 2: | 9c. License | number | | T | 29d. Date s | igned (Montl | n, Day, Year) | _ |
| H | | | > MBS NO | Win . | | | I | 59649 |) | | | U | 1/7 | 106 | |
| <u>}</u> | 0.2- | | 30. Name and address of person Ike Chukwu, M. | | | | | , MD 2 | 21044 | | | | 8. | | |
| 24 | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 13 | 2006 | 2. A pistrar's S | Signature' | and a | , | | | | | | | |

| State of Maryland / Department of Health and Mental | Hygiene nnc | 3701. |
|---|-------------|-------|
| Certificate of Death | Reg No. | 0104 |

| Physician |
|-----------|
| /Medical |
| Examiner |
| |

Funeral Director the Maryland

r then "natural", or items 23a or 28a-f ehow tra Medical Examinar must be cotified at filed within 72 hours after Hygiene. le marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Ie marked oths any Injury or other traumatic event, 9068.

Physician /Medical Examiner

physicien and s the burial-trans!t or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, use as the signed by the a peen certificate this within 24 hours effer death.

To the Funerel Director: After thi
completely filled in by the funeral

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Dawn Slater Alemar NOVEMBER 21, 2006 9:50A.M 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Reeders Memorial Home Boonsboro Washington 7. Age (In yrs. last birthday)

RO

If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Nov. 21, 1926 5. Social Security Number Birthplace (State or Foreign Country) 1 ☐ M 2 ☐ XF 195-20-0059 Pennsylvania Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d, Inside City Limits WV. Jefferson Shepherdstown Director 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 77 Cavalier View Ct. 25443 U.S.A Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Robert Slater Katherine ٩ Pearl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Alemar (Son) 77 Cavalier View Ct. Shepherdstown, WV. 25443 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Nov. 22, Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Md. 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home M01414 Smithsburg, Md. 21783 DAVIS Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepris 3 - 4 de Due to (or as a consequence of): Truct 3 - 4 don Sequentially list conditions, if any leading to him reflate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? malliting Di-fetis Uskerlennian 1 ☐ Yes 2 ☐ No 3 Probably 4 Hinknown Vanader 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Azuilu 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 (Aletural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tall MD D(8019 NOV 21, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VASANT DATTA, 340 MILL STREET, HAGERSTOWN, MARYLAND 21740 301-739-7100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 9 2006

10

| | | | 1 - For State Registrar | State of Mar | | artment of F | | | iene _{eg. N} 200 | 16 3 | 7850 |
|----------------------------|---|----------------|--|--|-----------------------------|--|-------------------------------------|--|--|---------------------------------------|---------------------------|
| П | Physic | ian | 1. Decedent's Name (First, Middle, Last |) | | | • | 2. Date of Dea Month | _ | 3. T | Time of Death |
| | /Medi | | Vernon | | Adkins, S | r. | | Novembe | r 19, 20 | 006 1 | 315 P ^M |
| 4 | Exami | ner | 4a. Facility Name (If not institution, give | street and number) | | 4b. City, Town, o | | ath | 4c. County o | | |
| | | | Union Hospital 5. Social Security Number 6. Securi | 7 400 / | In yrs. last birthday) | E1ktor | l If Under 24 H | re 0.0 | Ceci | | |
| | Funeral Director | | | M 2□F 71 | Yrs. last birthday) | Months Days | Hours M | | 9. Birthplace (State or Foreign Country) | | |
| | | | Usual Residence of Decedent | 71 | | <u>. </u> | | FED 25, | 1935 | Maryla | na |
| | how | | 10a. State 10b. County | 1 | 0c. City, Town or Lo | ocation | | | | 10d. In: | side City Limits |
| | Ba-f | cto | Maryland Cecil | | Elk Mil | 1s | | | | 1 5 | Yes 2□No |
| | ith th | Director | 10e. Street and Number | | | 10f. Zip Code | | 1 | 0g. Citizen of Wi | nat Country? | |
| | ath w | | 494 Elk Mills Ro | | | 21920 | | | United | States | 5 |
| | ltem nerro | Funeral | | 12. Was Decedent Eve Armed Forces? | er in U.S. 13. | Was Decedent of H If Yes, specify Cuba | lispanic Origin? an, Mexican, Pu | (Specify Yes or No- erto Rican, etc.) | | - American Ind White, etc. | ian, |
| 36 | Irs aff | by F | 1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates: | | 1 ☐ Yes 2 No | Specify: | | Specify: | | |
| Š | J within 72 hours after death with the Maryland jiene. rithan "natural", or Iteme 23a or 28a-f ehow The Madical Examiner must be notified at | ted | 15. Decedent's Edu | cation | 16a. Dece | dent's Usual Occup | ation | | 16b. Kind of Busi | White | |
| 218 | within 7 ene. than "n he Mad | pje | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4or 5+) | (Give | kind of work done of DO NOT use retired | durina most of w | vorking | Automob | | |
| 2 | filed with Hygiene ther thai | Completed | 11 | | As | sembler | | | Manufac | turing | |
| p | d is b | Be (| 17. Father's Name (First, Middle, Last) | | | | 18. Mother's N | ame (First, Middle, M | Maiden Sumame, | J | |
| Z | should to and Meni marked umatic | မ | Lemon C. Adkins | | | | | aret E. Ga | | | |
| Maryland 21215-0036 | C1 10 - 10 | | 19a. Informant's Name/Relationship (Ty | | | | | Rural Route Number | | |) |
| | s 1 and if Health item 27 other tr | | Loretta M. Adkins 20a. Method of Disposition | | P.U. 20b. Place of Dispo | | | ls, Maryla | | | |
| Baltimore, | | | 1 Burial 2 □ Cremation 3 □R | emoval from State | Cherry Hi | natory or other plac | | ember | 20c. Location - C | | |
| 듈 | 교투문문 | | 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License | | Methodist | Cemetery | ₇ 24, | 2006 | Cherry H | 1i11, M | D |
| 8 | 9079 | | 0 | 44 | Η̈́ | icks Home | for Fu | nerals, P. treet, Elk | Α. | | |
| | | | 23a. Part 1. Enter the disease, or compli | cations that caused the | death. Do not ent | or the mode of dying | GKTON S g, such as cardi | Treet, Elk ac or respiratory arre | cton, Ma | ryland | 21921 eximate |
| | nysician | | Immediate Cause (Final | ie cause on each line. | | | 1 | , | | Interv | al Between t and Death |
| | /Medical | | disease or condition resulting in death) | Due to (or as a c | onsequence of). | and in | -UTI Or | <u>ی</u> | | _ | |
| | Examiner | | Conventially list and the second | Co | PD | | | | | | |
| | 0 = | Iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a co | 1 1 | | | | | - | |
| 1 | ecute and trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | Ola | | rellle | | | | 100 | |
| 60, | cate be executed physicien and the burial-transit | JE E | and a second property of the second property | Due to (or as a co | onsequence of); | 126.00 | 00.0 | suffay | 27 | | |
| | | dical | d | | utenin | Vasco | cei n | 7 1111 | | | |
| × | death certiff e attending od for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 3c. If yes, outcome of p | pregnancy | | | | T | | |
| Вох | death a atter | ciar | in the past 12 months? | 1 Live birth 2 C 4 Pregnant at tim | Fetal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of Month | , | Year |
| P.O. | by the | hys | 9 Unknown | 9□ Unknown | | | | | | | |
| S, F | iaw requires that the death as been signed by the atter 2 should be detached for t | by P | Part II. Other significant conditions con | tributing to death but n | ot resulting in the ur | nderlying cause give | n in Part I. | 23e. Did tob | acco use contribi | ute to the caus | e of death? |
| D.C | w require been si should t | | | | | | | 1 🗆 Ye | s 2 🗆 No 3 | ☐ Probably | 4 Unknown |
| ec . | has be | Completed | | | | | | 24a. Was an | | re autopsy find | eldaliava available |
| œ , | age a | 5 | | | | | | perform | ed? dea | or to completion ath? Yes 2⊟ No | |
| /ita | yercian: The la is certificete has director, page 2 | Be | 25. Was case referred to medical examiner? | | | | 26. Place of De | eath Check only one | 4 | | |
| d | this c | P | 10 163 22 10 | ospital: | 2 POutpatient | | 4 Nursing | Home 5 ☐ Resider | | (Specify) | |
| LO. | After thi | ō | 27. Manner of Death 1 ☐ Matural 5 ☐ Pending | 28a. Date of Injury (Month, Day Ye | par) 28b. Time of Injury | 28c. Injury Work | ? | 28d. Describe how | v injury occurred | | |
| Division of Vital Records, | or Attending Projectan: after death. Director: After this certifice in by the funeral director. | fica | 2 Accident investigation 3 Suicide 6 Could not be | 28e. Place of Injury | At home farm stre | M 1 TY | es 2 No | 28f. Location (Stre | not and Mumber | | |
| <u> </u> | after dea Director d in by the | Certification: | 4 Homicide determined | building, etc. (S | Specify) | et, lactory, office | | City or Town, | State) | or Hurai Houle | Number, |
| | within 24 hours after deat To the Funeral Director: completely filled in by the | | 29a. Certifier 1 Certifying Phys | icien: To the best of m | y knowledge, death | occurred at the time | e, date and place | e, and due to the car | use(s) and mann | er as stated | |
| 3 | in 24 he Fu | edicai | (Check only 2 Medical Examin one) | er: On the basis of exa and manner stated | amination and/or inv | estigation, in my op | inion, death occ | curred at the time, da | te and place, and | due to the car | use(s) |
| , | within 2 To the Complet | Σ | 29b. Signature and title of certifier | | | 29c. License | | | d. Date signed (A | | |
| | , 1 | | on ce | e Ida | MD | D04 | 823 | 5 | 11/21/ | 26 | |
| | 0 | | 30. Name and address of person who cor | npleted cause of death | | Print) | | nan A | CILL | 11 | 12192 |
| | | | 31. Date filed (Month, Day, Year) | IT TIM | | 23 NE | est o | ran St | 0114 | THE | 9-11-1 |
| | Sta Registra | _ | NOV 2 9 20 | 32. ist ar's | Signature | colis | | | | | |

| Control Cont | | | | 1 - For Amend #11 Registrar | l Per Tille G | 862 112 | 27 26/06 Ce | artment of Hea rtificate of Dea | lith and Mo ath | ental Hy | giene Reg. No. | 2006 | 37851 |
|--|-------------|-------------------------------------|--------|--|---|----------------------|--------------------------|------------------------------------|--------------------|------------------------------|------------------------|---------------------|-------------------------|
| Andread Sample of Party Parts of an insulation print make and member of the Carp control and a Cap con | | Physic | | 1. Decedent's Name (First, Mid | ldle, Last) | | | | | | ath | . V | 3. Time of Death |
| Tall Cedar Day Drive Page 19 year 19 year | οίς | 2N- | | | James | Ot: | is Am | rein | | | 5/20 | 06 | 7:55 A M |
| Discland Social acceptance of Discland Proposed State of the Company Proposed State of | | Exami | ner | 4a. Facility Name (If not institut | ion, give street and num | iber) | | 4b. City, Town, or Loca | ation of Death | | 4c. County of Death | | |
| 212-20-0744 Tipus 21 Tipus 21 Tipus 21 Tipus 21 Tipus 21 Tipus 22 Tipus 21 | | | | | | | | | | | | | |
| The state of the country of the coun | * | | Ī | 212-20-0744 | | | | | | (Month, Da | v. Year) | Cou | intry) |
| Store The control of the control | | land w | | | ity | 10c. (| City, Town or Lo | ecation | | | | | 10d. Inside City Limits |
| Store Store | | Mary -1 eh | ţŏ | MD. Hs | arford | | | Fore | et Hil | ר | | | 1 |
| Store The control of the control | | h the | irec | | | | | | DO MIL | | 10g. Citiz | zen of What Cou | intry? |
| Second Comment Comme | | = 23 ≡ | aiD | 1302 W. Jari | rettsvill | e Ros | ad | 210 | 50 | | III | nited ! | States |
| Continued of the cont | | des des | Iner | 11. Marital Status | 12. Was Dece | dent Ever in | U.S. 13. | | - | ofy Yes or No | | 14. Race - Ameri | ican Indian, |
| The company of the | 036 | a 9 E | þ | | If Yes, Give | 9 | | 20.00 | | ican, etc.) | | 0 | |
| The part of the desired of the company of the com | 5-0 | 72 nat | etec | 15. Decede (Specify only high | ent's Education nest grade completed) | | 16a. Dece | dent's Usual Occupation | a most of working | 7 | 16b. Kir | nd of Business/Ir | ndustry |
| The property of the property o | 121 | e | g E | Elementary/Secondary (0-12) | | 4or 5+) | | | | | | | |
| State Stat | | iled v tygie ther t | | | 0 | | Se | | | | | | 15 |
| Physician (Medical Examiner) Physic | anc | od of | Be | | | | | | | | | | |
| Physician (Medical Examiner) Physic | Z | hould d Me mark matic | 12 | | | У | | | | | | | |
| Physician (Medical Examiner) Physic | E | nd 2 s Ith ar 27 is r treu | 1 19 | | | | | | | | | | |
| Physician (Medical Examiner) Physic | ē, | Hea Hea tem | | | ir erii/ boir | 20b. | Place of Dispo | sition (Name of | 10.00 | | | | |
| Physician (Medical Examiner) Physic | E C | Pages ent of nt: If I | | | | tate | | | 27/2 | 0/06 | | | |
| Physician (Medical Examiner) Physic | alt: | artm orter inju | 1 | | | рет В | 22 | Name and Address of S | Egodib. | | | | |
| Physician (Indicated the death. Co not enter the mode of bying, such as cardiac or respiratory arrest. Approximate in the case of complete time death of the complete time death of the case of conditions of the case of conditio | ä | Den Imp | 1 | IA N | 1/11/1/1/1/19 | 5 | E | G Kurtz & | Son Fu | ox 6 | Jarı | rettsv: | ille, Md. |
| Physician (Medical Examiner) The proposed of the state of the property of the | 8 | | ģ. | 23a. Part1. Enjoy the disease, of heart failure. Lis | or complications that ca st only one cause on ea | used the dea | ath. Do not ent | er the mode of dying, suc | ch as cardiac or | respiratory ar | rest, | 1107 2 62 | Approximate |
| Realing in death Due to (or as, deconsequence of) Due to (or as, deconsequence of deconsequence of deconsequence of deconsequence of deconsequence of deconsequence of deconsequence of deconsequence of deconsequence of deconsequence of deconsequence of deconsequence of deconsequence of deconsequence of deconsequence of decon | | Physician | | Immediate Caluse (Final | | 100 400 | markie | 0 < / | V.: | | | | Onset and Death |
| Second S | | | | resulting in death) | Due to (o | r as a conse | equence of): | - Comment | | | | | |
| The standing of each plant is a missage when the standing in each plant is a missage when the standing in each plant is a missage when the standing in each plant is a missage when the standing in each plant is a missage when the standing in each plant is a missage when the standing in each plant is a missage when the standing in each plant is a missage when the past 12 months? | 20 | Examiner | | Sequentially list sunditions. | | rora | ndry | arten | diala | · e e | | | |
| The standing of each plant is a missage when the standing in each plant is a missage when the standing in each plant is a missage when the standing in each plant is a missage when the standing in each plant is a missage when the standing in each plant is a missage when the standing in each plant is a missage when the standing in each plant is a missage when the past 12 months? | 7 | pe ##s | ine | if any, leading to immediate cause. Enter Underlying | Due to (o | r as a conse | equence of | _ / | | | | | |
| Second S | | and I-tran | хаг | inal initiated events | c. Due to (o | Myc | e de | -00- | | | | | |
| 25. Was case referred to medical examiner? 26. Place of Death Check only one! 27. Manner of Death Satural 5 Pending investigation of Part of Building, etc. (Specify) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28. Date of Injury - At home, farm, street, factory, office 28. Place of Death Check only one! 28. Place of Death Check only one! 28. Place of Injury - At home, farm, street, factory, office 28. Place of Injury - | 09 | be e sicien buria | | | 340 10 (0 | . 430 7 1130 | 14001100 01). | | | | | | |
| 25. Was case referred to medical examiner? 26. Place of Death Check only one! 27. Manner of Death Satural 5 Pending investigation of Part of Building, etc. (Specify) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28. Date of Injury - At home, farm, street, factory, office 28. Place of Death Check only one! 28. Place of Death Check only one! 28. Place of Injury - At home, farm, street, factory, office 28. Place of Injury - | 683 | ficate phys s the | dic | | d | | | | | _ | | | |
| 25. Was case referred to medical examiner? 26. Place of Death Check only one! 27. Manner of Death Satural 5 Pending investigation of Part of Building, etc. (Specify) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28. Date of Injury - At home, farm, street, factory, office 28. Place of Death Check only one! 28. Place of Death Check only one! 28. Place of Injury - At home, farm, street, factory, office 28. Place of Injury - | X | nding use a | | | 23c. If yes, outco | ome of pregr | nancy | | | | 20 | 2d Data of dalling | |
| 25. Was case referred to medical examiner? 26. Place of Death Check only one! 27. Manner of Death Satural 5 Pending investigation of Part of Building, etc. (Specify) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28. Date of Injury - At home, farm, street, factory, office 28. Place of Death Check only one! 28. Place of Death Check only one! 28. Place of Injury - At home, farm, street, factory, office 28. Place of Injury - | B. | death e atte d for | Cla | in the past 12 months? | | | | | | | 23 | | |
| 25. Was case referred to medical examiner? 26. Place of Death Check only one! 27. Manner of Death Satural 5 Pending investigation of Part of Building, etc. (Specify) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28. Date of Injury - At home, farm, street, factory, office 28. Place of Death Check only one! 28. Place of Death Check only one! 28. Place of Injury - At home, farm, street, factory, office 28. Place of Injury - | 0. | t the by the tache | hys | | 9□ Unknov | vn | | | | | | | |
| 25. Was case referred to medical examiner? 26. Place of Death Check only one! 27. Manner of Death Satural 5 Pending investigation of Part of Building, etc. (Specify) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28. Date of Injury - At home, farm, street, factory, office 28. Place of Death Check only one! 28. Place of Death Check only one! 28. Place of Injury - At home, farm, street, factory, office 28. Place of Injury - | S, | as tha | | Part II. Other significant condit | tions contributing to dea | th but not re | sulting in the ur | derlying cause given in F | Part I. | 23e. Did to | bacco us | e contribute to th | ne cause of death? |
| 25. Was case referred to medical examiner? 26. Place of Death Check only one 27. Manner of Death State 28. Date of Injury (Month, Day Year) 28. Date of Injury (Month, Day Year) 28. Date of Injury (Month, Day Year) 28. Date of Injury 29. Certifier (Check only 29. Signature and title of certifier 29. License number 29. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature | ord | en sig | ed l | atrial | februl | axu | er- | | | 1 🗆 Y | es 2 | No 3□Prob | ably 4 Unknown |
| 25. Was case referred to medical examiner? 26. Place of Death Check only one 27. Manner of Death State 28. Date of Injury (Month, Day Year) 28. Date of Injury (Month, Day Year) 28. Date of Injury (Month, Day Year) 28. Date of Injury 29. Certifier (Check only 29. Signature and title of certifier 29. License number 29. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature | o c | law re as be 2 sho | piet | | U | | | | | | | 24b. Were auto | psy findings available |
| 25. Was case referred to medical examiner? 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Mursing Home 5 Residence Mother (Specify) 1 Yes 2 No No No No No No No | | | E | | | | | | | perfor | 10022 | death? | _ |
| 27. Manner of Death Statural 2 Accident 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 3 Death 1 Death 2 Death 3 DoA 4 Nursing Home 5 Residence 6 Other (Specify) 2 3 Death 3 DoA 4 Nursing Home 5 Residence 6 Other (Specify) 2 3 Death 3 DoA 4 Nursing Home 5 Residence 6 Other (Specify) 6 Death 3 DoA 4 Nursing Home 5 Residence 6 Other (Specify) 6 Death 5 | /ita | ctor. | a | | al | | | 26. F | Place of Death (| | | 1 1 1 1 1 1 1 1 1 1 | 2 NO |
| State Stat | <u>></u> | hysic this ca al dire | ို | 1 ☐ Yes 2 No | Hospital: 1 ☐ Inp | atient 2 | ER/Outpatien | 3□ DOA Other: 4□ | Nursing Home | 5 🗆 Resid | ence 6 | Other (Specify | Residence |
| 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Montif. Day, Year) 29d. Date signed (Montif. Day, Year) 31. Date filled (Month, Day, Year) 32. Registrar's Signature | n | ing P | on: | | 28a. Date of (Month, | Injury Day Year) | | 28c. Injury at Work? | 28 | d. De <i>s</i> cribe h | ow injury | occurred | 100 |
| 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Montif. Day, Year) 29d. Date signed (Montif. Day, Year) 31. Date filled (Month, Day, Year) 32. Registrar's Signature | Sic | att :: e | cat | | not be | | | | | | | | |
| 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Montif. Day, Year) 29d. Date signed (Montif. Day, Year) 31. Date filled (Month, Day, Year) 32. Registrar's Signature | Σ | or A after Direction-by | ertif | | mined 286. Place o | , etc. <i>(Speci</i> | nome, farm, stre ify) | et, factory, office | 28 | Location (S. City or Town | treet and n, State) | Number or Rura | l Route Number, |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINDA ALWALSH MW 37/8 Normitville Roll Si, Ye C Jurre Haville MW 3/084 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature | _ | spitel lours nerei | | 29a. Certifier 1 Certifyi | ing Physician: To the b | est of my kn | owledge death | Occurred at the time, dat | to and place, and | d due to the e | nunc(a) = | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINDA AL WALSH MW 3718 Normisville Roll Si, Ye C Jurre Haville MW 3/084 State 31. Date filed (Month, Day, Year) 32, Registrar's Signature | | ne Ho | dic | (Check only 2 Medical one) | - LAGITIMION ON THE DAS | is of examina | ation and/or inv | estigation, in my opinion, | , death occurred | at the time, d | ate and p | lace, and due to | the cause(s) |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINDA AL WALSH MW 3718 Normal Ville Roll Si, Ye C Jurre Haville MW 3/1884 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | To the within To the Comp | | 29b. Signature and title of certific | er // | 0 0 | ^ | 29c. License numb | ber | 2 | 9d. Date | sig ed (Monti). | Day, Year) |
| State 31. Date filed (Month, Day, Year) 32, Registrar's Signature | | | 1 | Des elo | , a Wat | Sel- | - Mi) | P340 | 308 | | 11 | 11610 | 6. |
| State 31. Date filed (Month, Day, Year) 32 Registrar's Signature | | 15 | | A . | | | | Print) | | 1.64 | 11 | 1. ~ 1 | |
| State | 100 | 17 | - | The state of the s | | | | ld so, te C | Jagr | e XXVi | lle i | M) 21 | 084 |
| | | | G | | Date filed (Month, Day, Year) 32 Registrar's Signature | | | | | | | | |

| | | | 1 - For State Registrar | State of Maryland / | Department of Health and Certificate of Death | | ne ,2006 3785 | 52 |
|---------------------|---|------------------|--|--|--|---|---|--------------|
| | Physic | 20 | 1. Decedent's Name (First, Middle, La | st) | | 2. Date of Death | 3. Time of Dea | ith |
| | /Medi | | CHARLES | THOMAS | BOYD JR. | NOVEMBER | 13 2006 4:04P | М |
| | Exami | ner | 4a. Facility Name (If not institution, giv | | 4b. City, Town, or Location of Dea | th | 4c. County of Oeath | |
| 1 | | _ | SHADY GROVE HOS 5. Social Security Number 6. S | | ROCKVILLE | | MONTGOMERY | |
| | Funeral Director | | | ex 7. Age (In yrs. last bi | Yrs. Months Days Hours Min | | 9. Birthplace (State or For Country) WASHINGTON, D | reign) C |
| | land ow | | 10a. State 10b. County | 10c. City, Tov | vn or Location | | 10d. Inside City Lir | mits |
| | Man P-f sh | to | MD PRINCE G | EORGE'S OXO | N HILL | | 1X Yes 2□ | |
| | h with the 23a or 28s | Funeral Director | 10e. Street and Number 4907 GLASSMANOR D | RIVE # 301 | 10f. Zip Code 20745 | | Citizen of What Country? | |
| 036 | within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show the Medical Examinar must be notified at | þ | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U.S. Armed Forces? ARMY 1 MYes 2 □ No If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puei 1 ☐ Yes 2 ☑ No Specify: | Specify Yes or No- to Rican, etc.) | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| 5-0 | 72 hours "naturs!", idigal Exe | eted | 15. Decedent's Ed (Specify only highest gra | lucation 16a | Decedent's Usual Occupation | 16b | . Kind of Business/Industry | |
| 2121 | d within giene. | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | (Give kind of work done during most of wo life. DO NOT use retired) ELECTRICIAN | | RIVATE | |
| Maryland 21215-0036 | should be filed within nd Mental Hygiene. marked other than ' | To Be (| 17. Father's Name (First, Middle, Last) CHARLES T. BOYD | | | me (First, Middle, Maid N. MARSHA | | |
| ary | 0. 6 . 5 | | 19a. Informant's Name/Relationship (| ype, Print) 19t | D. Mailing Address (Street and Number or R | ural Route Number, Cit | y or Town, State, Zip Code) | |
| | 1 and 2 Health tam 27 i | | BETTYE J. BOYD/WI | | 07 GLASSMANOR DR. # | 301 OXON H | ILL, MARYLAND 2074 | <u> 5</u> |
| nore | ages 1 nt of H t: if Itan / or oth | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ | i ioiiio vai iroiii Otato | f Disposition (Name of ry, crematory or other place) | | Location - City or Town, State | |
| Baltimore, | permit. Pages Department of I important: if Its any injury or of | | 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen | | TERANS CEMETERY 11/2 22. Name and Address of Facility J | | ELTENHAM, MARYLAND NS FUNERAL HOME | _ |
| | 40 = e a | | X.0.19_ | hall | 7474 LANDOVER ROA | | ,MARYLAND 20785 | |
| | Physician /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) | a | not enter the mode of dying, such as cardia | | Approximate Interval Between Onset and Death MMWH | 25 |
| 68760, | ificate be executed g physicien and as the burial-transit | Ä | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence c. Due to (or as a consequence | | | | |
| 687 | ficate p phys | edlcal | | d | | | | _ |
| P.O. Box | death cert e ettendin id for use | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | 23d. Date of delivery Month Day Year | |
| Records, P | requires that the een signed by th hould be detache | d by PI | Part II. Other significant conditions co | ntributing to death but not resulting in | n the underlying cause given in Part I. | 23e. Did tobacc | o use contribute to the cause of death? | |
| Ö | w requir been si should | ete | | | | | / | |
| al Re | hysician: The law his certificate hes I director, page 2 (| Completed by | | | | 24a. Was an autopsy performed? | 24b. Were autopsy findings availal prior to completion of cause of death? 1 □ Yes 2₺ No | of |
| Vital | Physician: this certific ral director, | Φ | 25. Was case referred to medical examiner? | Hospital: | 0 | th Check only one | | |
| o | Attending Physic death. | tlon: To | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury 28b. 1 | tpatient 3 DOA | ome 5 Residence 28d. Describe how in | | |
| Division | 2 2 4 6 | Certification; | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At home, fa building, etc. (Specify) | | 28f. Location (Street City or Town, Sta | and Number or Rural Route Number, te) | |
| | B Hospitel 24 hours a Funeral I | Medical C | 29a. Certifier 1 Certifying Phy (Check only one) | sician: To the best of my knowledge ner: On the basis of examination and and manner stated. | , death occurred at the time, date and place d/or investigation, in my opinion, death occu | , and due to the cause(rred at the time, date a | s) and manner as stated. nd place, and due to the cause(s) | |
| | To the within 2 To the complet | Me | 29b. Signature and title of certifier | 4011 | 29c. License number | 29d. D | ate signed (Month, Day, Year) | |
| | | | 1 Call | Alle | m 04434 | 0 12 | 12 n/o 17 71 | m |
| R | 2 | | 30. Name and address of person who c ANGELO L. FALCON | completed cause of death (ftem 23a) (E. M.D. 9901 MEDIC | Type, Print) AL CENTER DRIVE ROCE | WILLE, MAR | YLAND 20850 | 00 |
| | Sta Registra | ~ | 31. Date filed (Month, Day, Year) NOV 1 6 2006 | 32. Registrar's Signature | ente | | | |

| | | | 1 - For State Registrar | | Maryla | nd / Depa | artmen tificat | t of H e of L | ealth ai | nd Men | tal Hygie | ene 200 | 6 37853 | | | |
|--|--|--|--|---|--|-----------------------------------|-----------------------------------|---------------------------------------|--------------------------------|---------------------------------|---|--|--|--|--|--|
| | Physica /Media | | Decedent's Name (First, Middle, La Louis Bose, Sr | • | | | | | | N. | Date of Death Month | Day Yea | | | | |
| | Examir | ner | 4a. Facility Name (If not institution, giv Southern Marylar | nd Hospit | d Hospital | | | | Location of | Death | | 4c. County of De | George's | | | |
| Ċ | Funeral Director | | 5. Social Security Number 6. S 578-56-9126 Usual Residence of Decedent | Sex 7. IS≵M 2□F | 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth | | | | | | | | 9. Birthplace (State or Foreign Country) Wash., D.C. | | | |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Heath and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Madical Extendred and be notified at once. | erai Director | 10a. State 10b. County Md. P.G. 10e. Street and Number 1218 Chapelwoo 11. Marital Status | od Lane | | | oitol 10f. Zip | Code 20 | 743 | | | U.S.A. | | | | | |
| | 2 hours after d | ted by Funerai | 1 Never Married 2⊠ Married 3 Widowed 4 Divorced 15. Decedent's Ec | Armed Force 1 Yes 2 If Yes, Give Year or Date | es? ⊠No | 16a. Deced | I □ Yes : | 2X No | Specify: | n? (Specify) Puerto Rican | | Black, W | Black | | | |
| Maryland 21215-0036 | led within 7 ygiene. her then "n it, the Med | Completed | (Specify only highest gra Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last) | College (1-4 | or 5+) | life. L | kind of wor DO NOT us eprer | e retired) | | | P | rivate I | • | | | |
| ryland | hould be fi d Mental H marked ott matic ever | To Be | Louis Bose Mildred Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Boute Number C | | | | | | | | | | | | | |
| re, Ma | permit. Pages 1 and 2 st Depertment of Health and Important: If Item 27 is n eny injury or other traun once. | | Reather Holloway 20a. Method of Disposition | Bose/Wif | | 1218 | Chap | elwo | od Lar | | itol H | gts.,Md. | 20743 | | | |
| Baltimore, | | | 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Nat 1. Mem. Park 11/18/06 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility H.S. Washington & Sons Co. Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 200 | | | | | | | | | | | | | |
| ä | age ag | | 23a. Part 1. Enter the disease, or compshock, or heart failure. List only | Plications that cau | sed the dea | th. Do not ente | H S W 4925 or the mode | ashi Burr e of dying | ngton oughs , such as ca | & Son Ave., | S CO., W. | Inc. ashingto | n,D.C.20019 Approximate Interval Between | | | |
| | Physician /Medical Examiner the principle of the principl | lical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Cop Due to (or | as a consec | TRY A | | | | EAS E | | | Onset and Death | | | |
| P.O. Box 61 | ath certifii ettending p for use as | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 1□Live birth 4□Pregnani | 3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | | | | | | | 23d. Date of d Month | elivery Day Year | | | |
| rds, P | w requires that the de been signed by the should be deteched | þ | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I | | | | | | | | _ | | to the cause of death? Probably 4 □Unknown | | | |
| tal Recc | | e Completed | 25. Was case referred to medical | | | | | | | | 4a. Was an autopsy performed ☐ Yes 2 | prior to death? | autopsy findings available occupietion of cause of us 2 No | | | |
| Division of Vital Records, | ding Pt After th funeral | Certification: To Bo | examiper? 1 Yes 2 No 27. Manner of Death 1 Accident | 28a. Date of In (Month, I | 26. Place of Death Check only one | | | | | | Residence | | ecity) | | | |
| D N | \$ # 5 E | | 4 Homicide determined | ome, farm, stre | | | | ty or Town, S | | | | | | | | |
| | To the Hospital within 24 hours a To the Funeral Completely filled | Medical | 29a. Certifier (Crisck only one) 1 Certifying Physical Example of Certifier 2 Medical Example and title of certifier | and manner | OI WARIINIIA | wledge, death tion and/or invi | astigation, | t the time in my opir License r | death o | place, and du occurred at th | ne time, date | and place, and du | e to the cause(s) | | | |
| 2 | ⊬ ≯ ⊨ ४ | | 30. Name and address of person who o | | f death (Item | 1 23a) (Time 5 | 1 | | 324 | | | Date signed (Month, Day, Year) IEMBER 13,2006 | | | | |
| | Sta | | TERRY TOD RIE, 1 | n.D. 7 | 1713 | | 775 | RO AH | O, CL | INTOP | UIMA | 24 LAMID | 20735 | | | |
| ů. | Registra | | NOV 1 6 2006 | Beech | D. | Sperke | | | | | | | | | | |

| Justin | Thomas-G | ill Brock |
|--------|-----------|-----------|
| JUSUII | THUINAS-O | III DIOCK |

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

| | | 1- For State Registrar Amend #28f_PerM | ED_P3C11=16=06ct ^{Ce} | rtificate of | Death | na Mentari | , 0 | eg. No. 201 | 06 3785 | | | | |
|--|--|---|--|--|----------------------------------|---|--------------------------------------|----------------------------------|---|--|--|--|--|
| Physici Medical Exam | ai i/ | 1. Decedent's Name (First, Middle,La Justin Thomas (| 0.7 | | | | 2. Date of Deat Month November | | 3. Time of Death | | | | |
| many and a second | | 4a. Facility Name (if not institution, gi | | 46 | . City, Town, o | or Location of Dea | | 4c. County of De | | | | | |
| | | 1510 Taylor Avenue Ft. Washington Prince George's | | | | | | | | | | | |
| Funeral Director | | | 7. Age (in yrs. i | last birthday) Yrs. | If Under 1 Ye Months Da | | | th(MM/DD/YYYY) 9. For 1988 | Birthplace (State or reign Country) | | | | |
| any | | Usual Residence of Decedent 10a. State 10b. County | 10c. City. | , Town or Location | n | | | | 10d. Inside City Limits | | | | |
| Maryland 28a-f show any d at once. | o | MD Prince (| George's Fort | Washing | gton | | | | 1 Yes 2 X No | | | | |
| r 28a-i ed at o | Director | 10e. Street and Number 1510 Taylor Ave | • | | 10f. Zip Code | , | 10 | g. Citizen of What C | • | | | | |
| 0036 within 72 hours after death with the Maryland yiene her than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once | | 11. Marital Status | 12. Was Decedent Ever in U | S 13 W/as | 2074 | lispanic Origin? (S | Concepts Von or No. | U. S. A | | | | | |
| death v r item | Funeral | 1 XX Never Married 2 Marrie | | | | an, Mexican, Puert | | White, etc | nerican Indian, Black, | | | | |
| s after o | by F | | d If Yes, Give Year | | es 2 X N | | | Specify: B1 | | | | | |
| 2 hours "natu | ted | 15. Decedent's Education (Specify of Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. Decedent's during mos | Usual Occupa t of working lif | ation (Give kind of e. DO NOT use re | work done tired) | 16b. Kind of Busines | ss/Industry | | | | |
| 5-0036 led within 72 hours after bygiene other than "natural"; the Medical Examiner | Completed | 12 | | Cashie | er | | | Grocery S | Store | | | | |
| 15-0036 filed within 72 I Hygiene ad other than ' | | 17. Father's Name (First, Middle, Las | () | 1 — - | | | e (First, Middle, M | laiden Surname) | | | | | |
| 2121 hould be fi nd Mental H is marked atic event, | o Be | 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State | | | | | | | | | | | |
| - S 8 L = | | Diane Snowden - | · Aunt | | | | | ngton, MD | | | | | |
| ore, M es I and 2 of Health If item 2 her traun | | 20a. Method of Disposition 1 XX Burial 2 Cremation 3 | | Place of Disposition of the Crematory or other | | emetery, | Date | 20c. Location - City | or Town, State | | | | |
| Baltimo permit Page Department of Important: injury or oth | | 4 Donation 5 Other Specify | Lin | coln Mem | orial | Cem. 11/ | 18/2006 | Suitland. | MD | | | | |
| Balt permit Departu Import | | 21. Signature of Funeral Service Live | Shinson | 22. Nar | ne and Addres | ^{ss of Facility} Be Branch As | 11 and J | ohnson Fur ple HIlls, | neral Home PA | | | | |
| Physician | | 23e art I. Enter the disease, or com | plications that caused the death. | . Do not enter the | mode of dying | g, such as cardiac | or respiratory arre | st, shock, or heart | Approximate Interval | | | | |
| /Medical Examiner | 1 | Immediate Cause (Final disease a | Hanging | | | | | | Between Onset and Death | | | | |
| | | or condition resulting in death) | Due to (or as a consequence o | f): | | | | | | | | | |
| | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | Due to (or as a consequence or | f)· | | | | | 1 | | | | |
| _ , ; | (Disease or injury that initiated C. Lue to (or as a consequence of): | | | | | | | | | | | | |
| secuted and rand | | | | | | | | | | | | | |
| 760, freate be executed by physician and the burial - transit | /Medical | IF FEMALE: | AMENDED 23c. If yes, outcome of pregr | nonov | | | | Lood Date of date | | | | | |
| x 68760, h certificate be tending physic use as the bur | | 23b Was decedent pregnant in the past 12 months? | 1 Live birth | 2 Fetal | death 3 | Ectopic pregn | ancy | 23d. Date of deliver | Day Year | | | | |
| Box 687 e death certifi the attending | Physician | 1 Yes 2 No 9 Unknow | Pregnant at time of de | ath 5 Othe | (Specify) | | | | | | | | |
| D.O. Be that the de ned by the detached f | | Part II. Other significant conditions | contributing to death but not re | esulting in the und | lerlying cause | given in Part I | 23e. Did tob | pacco use contribute | to the cause of death? | | | | |
| rds, P.O. | ed by | | | - | | | 1 Yes | 2 No 3 Pr | obably 4 🗸 Unknown | | | | |
| cords law requi has been 2 should | Completed | | | | | | 24a. Was a autops | y prior to | autopsy findings available completion of cause of | | | | |
| tal Rec | S | | | | | | perform 1 Yes 2 | | | | | | |
| Vital I hysician: this certifi I director, | e Be | 25. Was case referred to medical examiner? | Hospital: 1 Inpatient 2 | ER/Outpatient 3 | | e of Death (Check | | tesidence 6 🗸 Oth | ant Scone | | | | |
| 1 of Vital Records, ling Physician: The law require After this certificate has been si funeral director, page 2 should b | ㅂ | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Date of Injury | 28b. Time of Inju | | ry at Work? | 28d. Describe ho | ow injury occurred | er. Scerie | | | | |
| sion trendi death ctor: / | atio | Natural 5 Pending Accident Investigat | FOUND: Day, Year) Nov 12, 2006 | FOUND: 1053 hrs | 1 | Yes 2 V No | Subject hang | jed seit | | | | | |
| Division pital or Attendious after death teral Director: A | ertification | 3 Suicide 6 Could not determine | | | factory, office | building, etc. | or Town, Sta | ate) Ft Wash | Rural Route Number, City | | | | |
| Hospit Hospit 24 hour Funera ely fill | O | 4 Homicide | d (Specify) Single Familian: To the best of my knowledge | | at the time d | late and place, and | 1010 Taylor AV | Chuc, Moornoon , I | AD arted | | | | |
| Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans. | Medical | | r:On the basis of examination ar and manner stated | | | | | | | | | | |
| F × F ŏ | ž | 29b. Signature and title of certifier | , 11. | | 29c. Licens | | | 29d. Date signed (M | | | | | |
| | | Theodor | U. Ke JTR | mis. | O.C. | M.E. | | November 13, 2 | 2006 | | | | |
| (5) | | Name and address of person who Theodore M. King, Jr., ME | · - · | • | 11 Penn St | reet, Baltimor | e, MD 21201 | | | | | | |
| | tate 31. Date filed (Month, Day, Year) 32. Registrar's Signature trar NOV 1 6 2006 | | | | | | | | | | | | |
| Regist | rar | MAA T P SAMO | Deren D. | opera | | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 0 0 6 37855 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 11, BLOOM, JR. Ra1ph 2006 5:55aM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Homewood at Williamsport Washington Williamsport 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

86 Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 86 Yrs. Director 300-10-1185 Ohio Nov. 14,1919 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits in then "natural", or items 23s or 28e-f ehow the Medical Examiner must be notified at Williamsport 1 ☐ Yes 2X No Director Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia 21795 U.S.A. death v 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status filed within 72 hours after 1 XYes 2 No If Yes, Give V Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White W.W.II þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "na any njury or other traumatic event, the Madic once. Elementary/Secondary (0-12) 0-12 Coltege (1-4or 5+) chemical engineer mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ra1ph Bloom Ethe1 Cantor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Bloom, III - son 7825 Church Street, Middletown, Virginia 22645 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State November 11, 2006 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory Hagerstown, Maryland 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland₂₁₇₄₀ trud LiVestal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Infected Decubitus Ulcer, heel 3day5 /Medical Due to (or as a consequence of): Examiner Vascular Disease Teripheral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last chemic o months Due to (or as a consequence of): Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: Alter this certificete has been signed by the attending physicien and ed by the attending physicien and detached for use as the burial-transit Atheros deros is years Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Dementio Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ № 0 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 43 D47451 Cynthia Kuthner-sands, mo November 11, 2006 Cynthia Kuttner-Sands MD. Homewood at Williamsport, 16505 Virginia Avenue 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -Williamsport, Maryland 21795 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 3 2006 Registrar

| Physicia | | | | | | Cei | rtificate | of Deat | h | Reg | j. No. | | 3785 |
|--|--|--|--|--|--|--|--|--|--------------|--|--|--|---|
| rnysicia | | 1. Decedent's Name (First, Mid- | dle, Last, |) | | | | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
| /Medica | | Robert Olive | er Ba | arnard | | | | | | November | | 2006 | 8:45 P |
| Examine | er | 4a. Facility Name (If not instituti | - | | er) | | | wn, or Location | | | 4c. Count | ty of Death | |
| | | Stella Maris | | | | | | monium | | | 2 | | |
| uneral rector | | 213 28 3581 | Social Security Number 213 28 3581 6. Sex 1 Months Days Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. | | | | | | | 8. Date of Birth (Month, Day,) 8/18/19: | | olace (State or Foreigntry) 7land | |
| -22 | | Usual Residence of Decedent 10a. State 10b. Coun | lv | | 10c. City | , Town or Lo | ocation | | | | | 1, | I Od. Inside City Limit |
| Palet | 5 | | | | | | | | | | | | 1 ☐ Yes 2 ☑ N |
| 9 | ect | MD HOW 10e, Street and Number | vard | | E1 | licott | 10f. Zip Co | | | 100 | g. Citizen of | What Cour | |
| 3 | ᅙ | 3789 Plum Mea | dou | Dr | | | | 042 | | 103 | | | intery i |
| rdracmus | era | 11. Marital Status | | 12. Was Decede | ent Ever in U.S | S. 13. | | | Origin? (Spe | ecify Yes or No- | USA 14. Ra | 1ce · Americ | can Indian. |
| or other traumatic event, it a Mudical Examinar must be notified at | by Funeral Director | 1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce | arried | Armed Force | ^{es?} □№ 195 | 2- | lfYes, specify 1⊡Yes 2—∑ | Cuban, Mexic | an, Puerto | Rican, etc.) | Bla | ack, White, ify: Whi | etc. |
| E . | | 15. Decede | | | | 53 16a Dece | dent's Usual O | ecupation | | 1 16 | Sb. Kind of 8 | Bueinace/In | dueto |
| traumatic event, it a Mudic | Completed | (Specify only high | est grad | e completed) | | (Give | kind of work d DO NOT use re | lone durina mi | ost of worki | ing ' | DO. KHIQ OI I | Dusinessyni | dustry |
| 4 | Ē | Elementary/Secondary (0-12) | ' | College (1-4 | | Mani | factur | oric D | 272 | | Self- | -Ermal c | Sor v |
| Ē | ပို | 17. Father's Name (First, Middle | e, Last) | | | Paric | <u>irac cur</u> | | - | (First, Middle, Ma | | | yea |
| ; | To Be | Oliver G. Ba | rnar | rđ | | | | Acri | nes K | • Bopp | | | |
| E I | | 19a. Informant's Name/Relation | | | | 19b. Mailie | ng Address (St | | | i Route Number, (| City or Town | n. State. Zic | Code) |
| it i | | Kevin Barnard | l/sor | 1 | | | Fordh | | | timore, N | • | 229 | , |
| | | 20a. Method of Disposition | 10000000 | | 20b. PI | ace of Dispo | sition (Name o | of . | | - | c. Location | - City or To | own, State |
| | | 1 Surial 2 Cremation | | Removal from Sta | 21 9 | - | natory`or othei m Mom | | 37/1 | 4/2006 N | Tarciai a | | 11. MD |
| | | 4 □Donation 5 □ Other (| | | T CL | | | | | | | | ily FH I |
| any injury or other trai | | 1/20 / | 7 | 11/2/ | MO: | 1442 🥻 | 112 01 | d Colum | whia l | k. Elli | cott | City | шту ғы тг MD 2104 |
| | | 23a. Part1. Enter the disease, | ·KC | inations that any | and the death | | | | | | | CILLY, | Approximate |
| ner | ner | Cognostially list conditions | t | | | | | | | | | | |
| ne burial-transi | Ical Examiner | Sequentially list conditions, lary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | as a consequ | | | | | | | | |
| the bu | dical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | 0.00-170 | | | | | | | | |
| or use as the bu | dical | cause. Enter Underlying Cause (Disease or injury that initiated events | | Due to (or d. 33c. If yes, outco | me of pregnar n 2 ☐ Fetal at at time of de | ence of): | □Ectopic pregn □ Other (specif | | | | | ate of delive | ery Day Year |
| מומקומת וכן תפס מס ווופ מס | Physician/Medical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[\text{Yes} 2 \[\text{No} \] | 2 | Due to (or d | as a consequence of pregnar 2 ∐ Fetal it at time of de | ncy death 3[ath 5[| Other (specif | (y) | ti. | 23e. Did toba | М | lonth | |
| be detached for use as the bu | by Physician/Medical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | 2 | Due to (or d | as a consequence of pregnar 2 ∐ Fetal it at time of de | ncy death 3[ath 5[| Other (specif | (y) | t1. | | cco use cor | lonth | Day Year |
| inould be detached for use as the bu | by Physician/Medical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | 2 | Due to (or d | as a consequence of pregnar 2 ∐ Fetal it at time of de | ncy death 3[ath 5[| Other (specif | (y) | t I. | 1 ☐ Yes | cco use cor | ntribute to th | Day Year ne cause of death? nably 4 X Unknow |
| hould be detached for use as the but | by Physician/Medical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | 2 | Due to (or d | as a consequence of pregnar 2 ∐ Fetal it at time of de | ncy death 3[ath 5[| Other (specif | (y) | tl. | | CCO use cor | antribute to the second of the | Day Year ne cause of death? pably 4 X Unknow psy findings availab mpletion of cause o |
| lage z should be detached for use as the bu | Completed by Physician/Medical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condi | 2 tions con | Due to (or d. 3c. If yes, outcome of the pregnant of the pre | as a consequence of pregnar 2 ∐ Fetal it at time of de | ncy death 3[ath 5[| Other (specif | e given in Par | | 1 Yes 24a. Was an autopsy performe 1 Yes 25 | M cco use cor 2 □ No 24b. | antribute to the second of the | Day Year ne cause of death? pably 4 X Unknown psy findings availab |
| מספים הפים החומים ביים מספים היים מספים היים מספים היים מספים היים מספים היים מספים היים מספים היים מספים היים | Be Completed by Physician/Medical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condi | 2 2 sal | Due to (or d. 3c. If yes, outcomed to the pregnant of the pre | as a consequence of pregnar of 2 Fetal at at time of definition of the contract of the contrac | necy death 3 ath 5 ath | Other (specifing cause) | e given in Par | ce of Death | 1 Yes 24a. Was an autopsy performe 1 Yes 25 | M cco use cor 2 \(\text{No} \) 24b. | ntribute to the street of the | Day Year ne cause of death? pably 4 X Unknow psy findings availab mpletion of cause of 2 \(\square\$ No |
| מו מוסיסי ל בפרס ביו מו מיסיסיי מיסיסי מיסיסי מיסיסי מיסיסי מיסיסי מיסיסי מיסיסי מיסיסי מיסיסיי מיסיסי מיסיסי מיסיי מיסיי מיסיי מיסיי מיסיי מיסיסי מיסיסי מיסיסי מיסיסי מיסיסי מיסיסי מיסיסי מיסיסי מיסיסי מיסיסי מיסיסי מיסיסי מיסיי מיסיסי מיסי | To Be Completed by Physician/Medical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | 2 2 sal | Due to (or d | as a consequence of pregnate the sequence of pregnate that time of define the but not resultations attent 2 1 | necy death 3 ath 5 | Other (specifinderlying cause) | e given in Par 26. Pla Other: 4 | ce of Death | 1 Yes 24a. Was an autopsy performe 1 Yes 2\$ Check only one 1 Resident | M cco use cor 2 □ No 24b. 27 No | antribute to the second of the | Day Year ne cause of death? pably 4 X Unknow psy findings availab mpletion of cause of |
| | To Be Completed by Physician/Medical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | tions con | Due to (or d. 3c. If yes, outcomed to the pregnant of the pre | as a consequence of pregnate the sequence of pregnate that time of define the but not resultations attent 2 1 | necy death 3 ath 5 ath | Other (specifinderlying cause) out 3 DOA 28c. | e given in Par 26. Pla Other: 4 1 | ce of Death | 1 Yes 24a. Was an autopsy performe 1 Yes 25 | M cco use cor 2 □ No 24b. 27 No | antribute to the second of the | Day Year ne cause of death? pably 4 X Unknow psy findings availab mpletion of cause of 2 \(\square\$ No |
| | To Be Completed by Physician/Medical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | tions con | Due to (or d | me of pregnan 1 2 Fetal 1 at time of de 1 th but not resu 1 th but not resu 1 th put not resu 1 th put not resu 1 th put not resu 1 th put not resu 1 th put not resu | ncy death 3 (lath 5 (lath 28b. Time or Injury | Other (specifinderlying cause) ont 3 DOA 28c. | e given in Par 26. Pla Other: 4 1 1 Injury at Work? 1 Yes 2 | ce of Death | 1 Yes 24a. Was an autopsy performs 1 Yes 2 \$\frac{1}{2}\$ Check only one me 5 Resident 28d. Describe how | M cco use cor 2 \(\text{No} \) 24b. 27 No ce 6 \(\text{P}\) cinjury occu | onth 3 Prob Were auto prior to co death? 1 Yes ther (Specif | Day Year ne cause of death? pably 4 X Unknow psy findings availab mpletion of cause of 2 No HOSPICE |
| | To Be Completed by Physician/Medical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | tions con | Due to (or d. 3c. If yes, outcon 1 Live birth 4 Pregnan 9 Unknown htributing to deat dospital: 1 Inp. 28a. Date of I (Month, | me of pregnan 1 2 Fetal 1 at time of de 1 th but not resu 1 th but not resu 1 th put not resu 1 th put not resu 1 th put not resu 1 th put not resu 1 th put not resu | ncy death 3 [lath 5 [liting in the u | Other (specifinderlying cause) out 3 DOA 28c. | e given in Par 26. Pla Other: 4 1 1 Injury at Work? 1 Yes 2 | ce of Death | 1 Yes 24a. Was an autopsy performe 1 Yes 2\$ Check only one 1 Resident | M cco use cor 2 \(\text{No} \) 24b. 24b. 27 No ce 6 \(\text{No} \) ce 6 \(\text{No} \) et and Numer | onth 3 Prob Were auto prior to co death? 1 Yes ther (Specif | Day Year ne cause of death? pably 4 X Unknown psy findings availab mpletion of cause of 2 No HOSPICE |
| מו טווסכיטן, למשפ ב אויטטיט טפ טפומכיופט וטו עאפ מא ווופ טענ | Certification; To Be Completed by Physician/Medical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | tions constitued the state of t | Due to (or d. 3c. If yes, outcon 1 | me of pregname of pregname of pregname of pregname of the preg | ncy death 3 ath 5 | other (specifinderlying cause) at 3 DOA 28c. M eet, factory, of | e given in Par 26. Pla Cther: 4 1 1 Injury at Work? 1 Yes 2 [flice | ce of Death | 1 Yes 24a. Was an autopsy performe 1 Yes 2 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ | M cco use cor 2 \(\text{No} \) 24b. ce 6 \(\text{Cot} \) injury occu et and Num State) | onth 3 Prob Were auto or death? 1 Yes her (Specifiered | Day Year ne cause of death? pably 4 XUnknow psy findings available mpletion of cause of 2 No W HOSPICE At Route Number, |
| מו טווסכיטן, למשפ ב אויטטיט טפ טפומכיופט וטו עאפ מא ווופ טענ | To Be Completed by Physician/Medical | Cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | tions continued the ting the t | Due to (or Due to (or Due to (or Sc. If yes, outcon Clear of the pregnan Dunknown | me of pregname of pregname of pregname of pregname of the preg | ncy death 3 ath 5 | other (specifinderlying caused by the specific caused by the specifi | e given in Par 26. Pla Cther: 4 1 1 Injury at Work? 1 Yes 2 [flice | ce of Death | 1 Yes 24a. Was an autopsy performs 1 Yes 2 1 Check only one me 5 Residence 28d. Describe how 28f. Location (Stre City or Town, and due to the caued at the time, date | M cco use cor 2 No 24b. T No ce 6 Cot injury occu et and Num State) | Intribute to the strict of the | Day Year ne cause of death? pably 4 X Unknow psy findings available mpletion of cause of 2 No NO HOSPICE If Route Number, tated. the cause(s) |
| al director, page ∠ snould be detached for use as the bu | edical Certification: To Be Completed by Physician/Medical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | tions continued the ting the t | Due to (or d. 3c. If yes, outcon 1 | me of pregname of pregname of pregname of pregname of the preg | ncy death 3 ath 5 | other (specifinderlying caused by the specific caused by the specifi | 26. Pla Other: 4 1 Injury at Work? 1 Yes 2 [fice | ce of Death | 1 Yes 24a. Was an autopsy performs 1 Yes 2 1 Check only one me 5 Residence 28d. Describe how 28f. Location (Stre City or Town, and due to the caued at the time, date | Mocco use cor 2 No 24b. 24b. 27 No ce 6 10 Occ injury occu et and Num State) se(s) and me and place | antibute to the strict of the | Day Year The cause of death? |
| pletely filled in by the funeral director, page 2 should be detached for use as the bu | edical Certification: To Be Completed by Physician/Medical | Cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | tions confing tigation d not be mined in Examination | Due to (or d | me of pregname of pregname of pregname of pregname of the preg | ence of): ncy death 3 [eath 5 [liting in the u ER/Outpatier 28b. Time or Injury me, farm, str | other (specification) of the course of the c | 26. Pla Other: 4 1 Injury at Work? 1 Yes 2 [fice | ce of Death | 1 Yes 24a. Was an autopsy performs 1 Yes 2 1 Check only one me 5 Residence 28d. Describe how 28f. Location (Stre City or Town, and due to the caued at the time, date | Mocco use cor 2 No 24b. 24b. 27 No ce 6 10 Occ injury occu et and Num State) se(s) and me and place | Intribute to the strict of the | Day Year The cause of death? |

DHMH 17 Rev 1/2001

NOVEMBER 9, 2006 8:45 p.m.

Division of Vital Records, P.O. Box 68760, ROBERT BARNARD

| | | | 1 - For State Registrar | State of Ma | aryland | | artmen <i>tificat</i> | | | | | gienę Reg. Nd. | 006 | 3 | 7857 | | |
|-------------|--|-----------------------|--|--|------------------------------|--|---------------------------|--------------------|---------------------------------|-----------------|---|---|---|--|----------------------------------|--|--|
| | Physic | UUULU Maruaret Bronny | | | | | | | | | | | | ime of Death | | | |
| | /Medi Examir | | 4a. Facility Name (If not institution, give | street and number) | | | 4b. City, | Town, or | Location | of Death | | 4c. C | | | | | |
| | | | 7403 Buffalo Ave. | | | | | 1 | Takom | a Pa | rk | k Montgon | | | | | |
| | Funeral Director | | 5. Social Security Number 6. Social Security Number 147-42-8790 | 7. Ag | 6 (In yrs. I | ast birthday) Yrs. | If Under Months | 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Birt (Month, Da 03/29/ | h y, Year) | irthplace (State or Foreign Country) | | | | |
| | p , | | Usual Residence of Decedent | | 100 0:5 | | | | | | | | | | | | |
| | aryla •hov | 5 | 10a. State 10b. County | | | , Town or Lo | | | | | | | | 10d. Inside City Limits 1 Yes 2 No | | | |
| | 188-1 | Director | MD Montgom 10e. Street and Number | ery | так | oma Pa | | | | | | | | - 1 | 165 2 140 | | |
| | with I | 급 | 7403 Buffalo Ave. | | | | 10f. Zip | 912- | | | | _ | on of What (| Country? | | | |
| | eath | erai | 11. Marital Status | 12. Was Decedent | Ever in 115 | S 12 1 | | | anania Ori | ain? (Can- | oifu Van ar Na | USA | Doon Am | aniona tani | | | |
| 036 | be filed within 72 hours after death with the Maryland hat Hygiene. Id other than "naturel", or Itama 23a or 28a-1 show event, the Mexical Exarting ranal be notified at | by Funerai | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates: | f Yes, spec | offy Cubar | Specify: | i, Puerto F | cify Yes or No- Rican, etc.) | | I. Race - An Black, Wh Pecify: Wh | ite, etc. | ian, | | | | |
| 20 | 72 hc | ted | 15. Decedent's Ed (Specify only highest gra | | | 16a. Deced | lent's Usua kind of wo | | | t of workin | | | of Busines | , | | | |
| 21215-0036 | d within giene. or than " | Completed | Elementary/Secondary (0-12) | College (1-4or 5 | | Execu | DO NOT us | se retired) |) | | 9 | | profi nizat | | | | |
| ᅙ | 2 should be filed vand Mental Hygie is marked other raumatic event, the | 0 | 17. Father's Name (First, Middle, Last) James Brophy | | | | | | | | (First, Middle, availab | | итате) | | | | |
| Maryland | nd 2 shoi aith and N 27 is ma r trauma | | 19a. Informant's Name/Relationship (7 Lance A. Miller/Hu | | | | - | | | | Route Numbe | | , | , , | | | |
| Baltimore, | iit. Pages 1 and 2 should be artment of Health and Menta prtant: if Item 27 is marked injury or other traumatic ev | | 20a. Method of Disposition 1 □ Burial 2 ⊠ Cremation 3 □ 4 □ Donation 5 □ Other (Specify | | ce | ace of Dispo emetery, cren esapea! | natory`or o | ther place | | | -2006 | | . Location - City or Town, State eltsville, Maryland | | | | |
| Balti | permit. Page Department of Important: ff eny injury or once. | | 21. Signature of Funeral Service Licen | see M | 00382 | 22 R | | d Address unera | s of Facilit | remat | ion Ser Spring | | | 20910- | | | |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | olications that caused | the death | | | | | | | | yranu | Appro | ximate | | |
| k.ft. | Physician /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) | a. Pi+ | wito | Lry | 0 | | ma | | | | | | al Between and Death YEQTS | | |
| 8760, | death certificate be executed e attending physician and idr use as the burial-transit | ai Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. — Due to (or as c. Due to (or as | | | | | | | | | | | | | |
| 687 | phys phys the | dicai | | d | | | | | | | | | | | | | |
| .O. Box (| | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown | 23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown | 2 Fetal | death 3 | Ectopic pre Other (spe | | | | | 236 | 23d. Date of delivery Month Day | | Year | | |
| ۵. | requires that the de een signed by the a hould be detached t | þ | Part II. Other significant conditions co | entributing to death be | ut not resul | Iting in the ur | derlying ca | ause give | n in Part I. | | | | contribute | | | | |
| Ö | w requir been si should | ted | THEFOLEN THEIR | reed Di | 000 | 103 | | | | | 1 🗆 Y | es 2 | NO 3 1 | robably | 4 Unknown | | |
| al Records, | The larate has | Completed | | | | | | | | | 24a. Was a autop: perfor | sy | prior to death? | utopsy find completion s 2 No | dings available n of cause of | | |
| Vital | ician: certific rector, | Be | 25. Was case referred to medical examiner? | Hospital: | - | | | 11.0 | | of Death | Check only or | 16) | | | | | |
| 5 | Phys this al dii | 7 | 1 ☐ Yes 2 No 27. Manner of Death | 1 L Inpatie | | R/Outpatien 28b. Time of | | | 4 LI NU | - | e 5 🔣 Resid | | | ecify) | | | |
| n | ding h. h. After funer | ion | 1 XNatural 5 Pending | 28a. Date of Injur (Month, Da) | Year) | Injury | | 8c. Injury Work | | | 3d. Describe h | ow injury o | occurred | | | | |
| Division of | or Attendifter death | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injubulding, etc. | ury - At hor c. (Specify) | me, farm, stre | M eet, factory | | es 2 🗍 l | - | | ocation (Street and Number or Rus City or Town, State) | | | Number, | | |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune. | Medicai Ce | 29a. Certifier 1 Certifying Phyone 2 Medical Examone) | rsicien: To the best of | examinati | viedge, death on and/or inv | occurred a | at the time | e, date and inion, deal | d place, ar | nd due to the c | ause(s) ar late and pl | nd manner a | s stated. | use(s) | | |
| | thin S thin S the mple | Mec | 29b. Signature and title of certifier | and manner sta | | | | License | | | | | | | | | |
| | F 3 F 8 | | A Man | A | 10 | | | | | / | | | signed (Mor | | rai) | | |
| 1 | 20 | | Hander IM. | Dune | 7 mi | > | 1 | 153 | 99 | 6 | | 11- | 10 - | 06 | | | |
| | | | 30. Name and address of person who o | ompleted cause of de | eath (Item | 23a) (Type, I | Print) | | 0 | , # | 71.4m 1 | . /1 | 1 | 1 / 5 | 20902 | | |
| | | | 31. Date filed (Month, Day, Year) | 32 Registra | ar's Signati | JU/Ur | river | 514 | y BI | Vd. | 400 V | Vhec | iton | IND | 20402 | | |
| | Sta Registr | - | | 06 | 1 | A SOL | Mes | | • | | | | | | | | |

| | | For | ricuse | State of M | | - | artmen | t of H | ealth a | | • | giene | | | 7050 | | |
|--|------------------|--|--|--|---|---------------------------------|-----------------------------|------------|------------------------------|------------|------------------------------------|----------------------|------------------------------|-------------------------|---------------------------------------|--|--|
| | | 1 - State Registrar | (First Middle Loo | 41 | | Ce | rtificat | e of L | Death | | 2. Date of De | Reg. No. | UUb | <u> </u> | Time of Death | | |
| Physi | | 1. Decedent's Name | e (First, Middle, Las | popina | , P |) Xoern | DV | | | | Month | Day | Yea | ş 3. | 10 PM | | |
| /Med Exam | dical | 4a Facility Name (/ | fort institution, give | street and number | r) | DELL | T | Town, or | Location of | Death | | 4c. | County of De | ath , | <i>Q</i> | | |
| * 3 | | Cottma | 2, 11. | sina Hor | | | HA | | Stown | | | lu | ashi | rito | n | | |
| Funera | | 5. Social Security N | | X 7. A | ge (In yrs. 98 | last birthday) Yrs. | If Under Months | Days | If Under 2 Hours | Min. | 8. Date of Bir (Month, Da | rth ay, Year) | 9. € | introlace Country) | (State or Foreign | | |
| Directo | or | Usual Residence of | Decedent | | 90 | 113. | | | | | 6/23/ | 1908 | | | MD | | |
| yland | | 10a. State | 10b. County | | 10c. Cit | ty, Town or L | ocation | | | | | | | | side City Limits | | |
| e Ma | ctor | MD | Washingt | on | На | gersto | | | | | | | | | Yes 2 No | | |
| death with the Maryland rms 23a or 28a-1 show | Funeral Director | 10e. Street and Nur 1359 Sale | | | | | | .740 | | | : | 10g. Citiz | Country? | | | | |
| deati | ner | 11. Marital Status | | 12. Was Deceder Armed Forces | t Ever in U | .S. 13. | Was Dece | dent of Hi | spanic Orig | in? (Spe | cify Yes or No Rican, etc.) | 0- 1 | 14. Race - Ai Black, W | | dian, | | |
| IZID-UU30 within 72 hours after death with the Marylar ene. then "natural", or items 23s or 28s-1 show then "matural", or items 23s or 28s-1 show in Medical Examiner must be notified at | | 1 Never Marr | ied 2□ Married 4 ∑ Divorced | 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates | No | | 1 🗆 Yes | | Specify: | | | | Specify: | Whi | te | | |
| 72 h | Completed by | (Spec | 15. Decedent's Ed | | | 16a. Dece (Give | dent's Usu | al Occupa | ation during most) | of workin | g | 16b. Kir | nd of Busine | ss/industr | 1 | | |
| within then then | dmo | Elementary/Seco | indary (0-12) | College (1-4o | r 5+) | | emake | | , | | | | | Home | | | |
| Hygined thyginether | 0 | 17. Father's Name | (First, Middle, Last) | | | , | | | 18. Mother | r's Name | (First, Middle | , Maiden | | OILLO | | | |
| YIBING tould be fill I Mental Hi Trarked oth | To B | Daniel Vi | ctor Stot | ler | | | | | | | la Tie | | У | | | | |
| and and and seum | | | ame/Relationship (7 Harbaugh) | | ghter | | - | | | | Route Numb | | | | e) | | |
| s 1 and f Health Item 27 other tr | | 20a. Method of Dis | position | | 20b. F | Place of Disponentery, cre | osition (Na | me of | 1 | | ate | | cation - City | | State | | |
| 00 | | 1 ☑ Burial 2 4 ☐ Donation | ☐ Cremation 3 ☐ 5 ☐ Other (Specify | Removal from Stat) | 6 | se Hil | • | | | L/18/ | /2006 | Нате | rstowr | ı, MD | | | |
| Battimore, permit. Pages 1 a Department of Hee Important: If Hem any njury or othe | 9 | 21. Signature of Fu | meral Service Licen | see | 0 | 100 | | | s of Facility | Ger | ald N. | Min | nich F | unera | 1 Home | | |
| | a | 2 = | he disease, or comp rt failure. List only | * | 2 | | | | | | et, Ha | _ | cown, | | .740 roximate | | |
| Physician / Medica Examine Physician end Physician end Physician end Physician en P | ical Examiner | Immediate Cause disease or condition resulting in death) Sequentially list confianty, leading to incause. Enter Under Cause (Disease or that initiated events resulting in death) | (Final on the state of the stat | a. Due to Due to (or a c. Due to (or a d. | s a consecutive a consecutive a | tille 18 / Juence of). | nell | itos | | | | | | 710 | Plans Plans | | |
| IS, P.O. BOX 080, res that the death certificate signed by the attending phy be detached for use as the | Physician/Med | IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 (9 ☐ Unknown | months? | 23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown | 2 Feta | al death 3 | ⊒Ectopic p ⊒ Other (s | | | | | 2 | delivery Day | Year | | | |
| HECOTAS, P.O. The law requires that the ten bas been signed by the base should be detached. | by Pi | - A10 | ficant conditions of |) - | but not res | sulting in the t | anderlying o | cause give | en in Part I. | | 23e. Did | tobacco u | se contribute | to the ca | use of death? | | |
| VITAI HECOPOS iicien: The law requires certificate has been sign | ted | - 19 | Mertine | con- | | | | | | | 1 🗆 | Yes 2 | 4No 3□ | Probably | 4 □Unknown | | |
| leC slaw r has be e 2 sh | Completed | | | | | | | | | | 24a. Was | psy | 24 Were prior to death | o complet | ndings available ion of cause of | | |
| VITAI HEC sicien: The law certificate has rector, page 2 ! | ပ် | | | | | | | | | | | ormed? 2 No | | es 2 | No | | |
| 99 | o Be | 25. Was case reference examiner? | | Hospital: | tient 2 |] ER/Outpatie | nt 3 🗆 De | Othe | 00 | | <i>iiCh</i> eck only ne 5 ☐ Res | | COther /S | naciful | | | |
| On OT ding Phy h. After this funeral d | Ë | 27. Manner | th | 28a. Date of In | jury | 28b. Time o | | 28c. Injun | | | 8d. Describe | | | Decity) | · · · · · · · · · · · · · · · · · · · | | |
| VISION (Attending I r death. ector: After by the funer | atlo | 1 Accident | 5 Pending investigation | | ay roar, | ,, | М | | Yes 2□N | No. | | | | | | | |
| 2 # # C | Certification: | 3 Suicide 4 Homicide | 6 Could not be determined | 288. Place of I | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Str. City or Town) | | | | | | | | | Aural Aoi | ite Number, | | |
| DIVI Do the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by | edical (| 29a. Certifier (Check only one) | 1 ☐ Certifying Ph 2 ☐ Medical Exam | ysician: To the be- niner: On the basis and manner | of examina | owledge, dea ation and/or in | th occurred nvestigation | at the tim | ne, date and pinion, deat | d place, a | ind due to the od at the time | cause(s) date and | and manner place, and c | as stated lue to the | cause(s) | | |
| To the To the comp | ž | 29b. Signature and | title of certifier | 1 | | | 29 | C. License | e number | - | | | e signed (Mo | | | | |
| | | >7 | more (n | AT . | | | 1 | 154 | () > | | | nov | 17 | 20 | OP | | |
| SH-5 | | 30. Name and add | East (| completed cause of | death (Iter | (23a) (1)00a | Printy | ie | 200 | · H | byers | Fruk | 17 j | on. | 140 | | |
| Regi | State strar | 31. Date filed (Mor | nth, Day, Year) | | strar's Signa | ature | 10.11 | , | | | , | | (| | | | |

DHMH 17 Rev 1/2001

ORIGINAL

| | | 4 | For | riease | | | | | artmen | t of H | ealth a | and M | lental H | | _ | | 378 | 159 |
|---|--------|----------------|--|-----------------------|---------------------------------|----------------------------------|------------------|----------------------------------|--------------------------|-----------------------------|--|------------------------|-------------------------------|---------------------------|------------------------------|----------------|------------------------|---------------|
| | | | State Registrar | | • | | | Cei | rtificat | e of L | Death | | 2. Date of D | Reg. No. | . 0 0 0 | | | |
| Phys | sicia | | Decedent's Name (| | | | | | | | | | Month | Day | | ar | 3. Time of | P M |
| /Me | edica | al - | Emma Vale la. Facility Name (If n | | | | | | 4b. City. | Town, or | Location of | of Death | Nov. | 15 4c. | _ <u>2006</u> County of D | | :50 | Ъ |
| Exa | mine | r | Williamsp | | | | | | | | sport | | | | Vashin | | 1 | |
| Fune | ral | | 5. Social Security Num | | Sex 1 □ M 2 📉 | 7. Ag | e (In yrs. | last birthday) | If Under Months | 1 Year | If Under | | 8. Date of B (Month, D | | | | | or Foreign |
| Direct | or | - | 219-12-19 | | 1 L M 2401 | | 88 | Yrs. | | | | | Feb. 1 | | | lary1 | | |
| land ow | | | Usual Residence of D 10a. State 1 | Ob. County | | | 10c. Cit | y, Town or Lo | ocation | | | | | | | 10d. | Inside C | ity Limits |
| Mary I-f eh | | 5 | Md. | Washing | gton | | | Hanco | ck | | | | | | | | 1 🗌 Yes | 2 ∑ No |
| death with the Maryland ms 23a or 28a-f ehow | | Director | 10e. Street and Numb | er | | | | | 10f. Zip | Code | | | | 10g. Citi | zen of What | Country | ? | |
| ath wi | | | 14510 Hea | venly A | | | | | | | 750_ | | | UŞ | | | | |
| er de | | Funerai | Marital Status 1 ☐ Never Married | 2□ Marriad | | Decedent d Forces? es 2√⊡! | | .S. 13. | Was Dece If Yes, spe | dent of Hi cify Cuba | spanic Ori n, Mexican | gin? (Spe 1, Puerto | cify Yes or N Rican, etc.) | 10- | 14. Race - A Black, W | | | |
| within 72 hours after ene. then 'naturel', or ite the Madical Exemina | | 2 | 3 Widowed 4 | | If Yes. | , Give or Dates: | 40 | | 1 🗆 Yes | 2 ∑ No | Specify: | | | | Specify: | Whi | te | |
| 72 hou | | Completed | (Specific | 5. Decedent's I | Education | ad) | | 16a. Dece | dent's Usu kind of wo | al Occupa | ation | t of works | na | 16b. Ki | nd of Busine | | | |
| ilthin 7 | | nple. | Elementary/Second | | | ge (1-4or 5 | 5+) | life. | DO NOT u | se retired, |) | | 9 | | | | | |
| V 255 | 1 | ខ្ញ | 8 17. Father's Name (Fi | rst Middle Las | O_ | | | B | <u>locke</u> | r | 18. Mothe | ar's Name | (First, Middi | | obon M Sumama) | lfg. | | |
| d be file | | To Be | Archie Ca | , | , | | | | | | | | Tagle (| | | | | |
| Taryla 2 should be and Ment 1s marked | | ř | 19a. Informant's Nam | | (Type, Print) | | | 19b. Mailii | ng Address | (Street a | | | I Route Num | | | e, Zip Co | ode) | |
| of the | | | Marylan K | Cochera | - Dau | hter | : | | | | | | Hanco | ck, M | d. 217 | 750 | | |
| of He | | | 20a. Method of Dispos | | ∏Removal fr | om State | 20b. F | Place of Dispo cemetery, crea | natory or o | me of other place | θ) | | Date | 20c. Lo | cation - City | or Town | , State | |
| mit. Pages purtment of portant: If i | | | 4 Donation 5 | Other (Spec | cify) | | Ceda | ar Law | | | the second secon | | | | rstow | | lary1 | and |
| baltimore permit. Pages 1 a Deportment of He Important: If item | Suc | | 21. Signature of Fune | ral Service Lici | ensee | | | | 2. Name ar | | | | innich . Hagei | | | | 740 | |
| | | | 23a. Part1. Enter the shock, or heart | disease, or con | mplications th | nat caused | d the deat | | | | | | | | n, riu. | A | pproximat | te e |
| Diversini | | | Immediate Cause (Fi | | | _ ' | 1 = - | | | • | | | | | | ,0 | terval Bet nset and | |
| Physicia /Medic | _ | | disease or condition resulting in death) | 4 | | | a conseq | uence of): | eum | OFIC | يا: | | | | | da | LYS. | |
| Examin | | | Sequentially list cond | itions | | | hagi | | | | | | | | | -00 | ,, †, 2 | 5 |
| pe is | | iner | Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in | ediate d | | | ra compound of): | | | | | | | | | | | |
| bU, be executed icien and burial-transit | | Examiner | that initiated events resulting in death) La | | | uence of): | LP: | dist | ease | | | | - Ye | ars | | | | |
| BOX 68 / 6U, eath certificate be executed ettending physicien and for use as the burial-transit | | calE | | · · | d === | | | | | | | | | | | | | |
| certificate ding phy | | - | | | <u> </u> | | | | | | | | | | | | | |
| SOX lath cer attendin for use | | Physician/Med | IF FEMALE: 23b. Was decedent p | | 23c. If yes, 1⊟Li | | of pregna | |]Ectopic p | гедлалсу | | | | | 23d. Date of Month | delivery Da | | Year |
| the death y the etter | | /sici | in the past 12 m 1 ☐ Yes 2 ☐ 1 9 ☐ Unknown | | | regnant a nknown | t time of d | leath 5 | Other (s | pecify) | | | | | MORUT | Da | 19 | i bai |
| that the de detached f | | P. | Part II. Other signific | ant conditions | contributing | to death b | out not res | ulting in the u | inderlying o | cause give | en in Part I | | 23e. Dio | tobacco u | se contribut | e to the o | cause of o | death? |
| HECONDS, P. The law requires that the has been signed b | | d b | | | | | | | | | * | | 1 🗆 | Yes 2 | ⊒ No 3□ |] Probab | ly 4 □ | Unknown |
| COT IW req s beer shou | | Completed | | | | | | | | | | | 24a. Wa | | 24b. Were | autopsy | y findings | available |
| The lay | | E | | | | | | - | | | | | aut per 1 ☐ Yes | opsy formed? 2 D No | death | | letion of d □ No | ause or |
| VITAL P sician: Th certificate rector, pac | | Be | 25. Was case referre | d to medical | | W | | (A) | | | | | Check only | one | | | | |
| OT V Physic | | ှ | 1 ☐ Yes 2 ☐ N | Ó | - | I 🗌 Inpatio | | ER/Outpatie | | | | | me 5□Re | | | Specify) | | |
| On C ding P h. After | | ü | 27. Manner of Death 1 Natural | 5 Pending investigate | (1 | ate of Inju Month, Da | iry iy Year) | 28b. Time o Injury | M | 28c. Injun Worl 1 □ ' | /at <br Yes 2□ | | 28d. Describe | now injur | y occurred | | | |
| eat eat | | ficat | 2 Accident 3 Suicide | 6 Could not determine | be 28e. P | | | ome, farm, st | | | | - | 28f. Location | | | r Rural R | Route Nun | nber, |
| 2 th 2 is | | Certification: | 4 Homicide | 4 | Ь | uilding, et | tc. (Specil | <i>(Y)</i> | | | | | City or I | own, State |) | | | |
| To the Hospital or within 24 hours efter To the Funeral Director Completely filled in I | | | 29a. Certifier 1 (Check only 2 | Certifying f | Physicien: To aminer: On the | the best | of my kno | owledge, deat | h occurred | at the tim | ne, date an | nd place, | and due to th | e cause(s) | and manne | r as state | ed. ne cause(s | s) |
| To the H within 24 To the F | | Medical | one) | | and r | manner st | ated. | | | | | | | | | | | |
| 5 ± 5 5 | 3 | | 290. Signature and th | M LA | Kutt | ner - | Sa | ndo n | 9 | Λ 4 | 745 | / | | No.10 | m /22 c | 15 | 200 | 6 |
| | | | 30 Name and address | is of person wh | o completed | cause of | death (Iter | n 23a) (Type | Print) A | 1 | 0 110 | / ~^ C | 10.1.1 | - LOPE | 11.00 | , -, | · C.+~ | 200 |
| DH-1 | | | Cynthia. | Kuttner | -Sands | MD | W. III | unspol | ~ + '/\ | MZIN | J-201 | liam | 134N | + M | 2ryla | nd | 217 | 75 |
| | Stat | te | 29b. Signature and till Gynt 30. Name and address Cynthio 31. Date filed (Month) | Day, Year) | 2006 | 32. Togisti | rar's Signa | ature _ | | | | | 1 | 1 | 7 | | | |
| Reg | jistra | ar | N | UVIO | 2000 | Beels | ear , | 19. Ly. | ande | , | | | | | | | | |

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ca

and manner stated

S

68

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Acrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00062327

Hairs town ind.

29d. Date signed (Month, Day, Year)

| | | | 1 - For State Registrar | State of Mary | | artment o | | | nd Menta | Hygiei | 2Π | 06 | 378 | 61 |
|-----------------|---|------------------|---|---|--|----------------------------------|-------------------|-------------------|-------------------------------------|---------------------------------|------------------|-----------------------------------|------------------------------|-----------|
| | A so | | 1. Decedent's Name (First, Middle, La. | st) | | | | | | of Death | | | 3. Time of | Death |
| | Physic /Medi | | Ralph Andrew Bren | neman | | | | | Nove | | 13, | 2006 | 3:00 | РМ |
| | Exami | | 4a. Facility Name (If not institution, give | e street and number) | | 4b. City, Tov | wn, or Lo | cation of | Death | | | ty of Death | 15000 | |
| | | Ç. | 8025 Rock Lodge R | d. | | Accide | ent | | | | Garr | ett | | |
| E | Funeral Director | | 214-14-7910 | ex 7. Age (In 8 | yrs. last birthday) 8 Yrs. | If Under 1 Y Months D | | Under 24 Hours | Min. 8. Date (Mor. NOV | of Birth th, Day, Ye 29,1 | . 917 | 9. Birthp Cour Mary | lace (State o | r Foreign |
| | and and | | Usual Residence of Decedent 10a. State 10b. County | 10c | . City, Town or Lo | cation | | | | | | 1 | Od. Inside Cit | by Limite |
| | the Marylan 28a-f ehow notified at | ō | MD Garrett | AC | cident | | | | | | | | 1 Tes | - |
| | 1 the | Funeral Director | 10e. Street and Number | 710 | 0100110 | 10f. Zip Co | de | | | 10g. | Citizen of | What Cour | ntry? | |
| | h with | D E | 8025 Rock Lodge R | đ. | | 215 | 20 | | | USA | | | , | |
| | dea | ner | 11. Marital Status | 12. Was Decedent Ever Armed Forces? | | Was Decedent | of Hispa | nic Origin | n? (Specify Yes Puerto Rican, et | or No- | 14. Ra | ice - Americ | | |
| 21215-0036 | within 72 hours after death with the Manyland ene than "natural", or itame 23e or 28e-f ehow is Mudisal Examinar must be notitized at | b | 1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | | 1 ☐ Yes 2 X ☐ | | Specify: | ruento Alcan, el | ic.) | | ack, White, ^{My:} Whi | | |
| 5-0 | 72 h | Completed | 15. Decedent's Ed (Specify only highest gra | lucation de completed) | 16a. Dece | dent's Usual O | ccupation | n na most o | t working | 16b | . Kind of E | Business/Ind | dustry | |
| 121 | ne hen | mp | Elementary/Secondary (0-12) | College (1-4or 5+) | | kind of work di DO NOT use re | | | | Co | al a | | | |
| N | Hygie thert | | 17. Father's Name (First, Middle, Last) | | Coai | Miner | | | | Aladada Ada ia | | icult | ure | |
| Maryland | 2 should be filed within " and Mental Hygiene. Fie marked other than " raumatic event, II e Med | To Be | Dennis Brenneman | | | | Ma | ary C | s Name (First, A Dester | | | | | |
| | is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Itam 27 ie marked other than "natural", or itame 23a or 28a-f ehove traumatic event, it a Medical Examinational be notified at | | 19a. Informant's Name/Relationship (19marie Brenneman/ | ** | | | | | or Rural Route I | | | n, State, Zip 1520 | Code) | |
| Baltimore, | Pages 1 and of He Int; If Itan | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify | Removal from State | b. Place of Dispo cometery, crer sittinger | natory or other | place) | Nov | Date . 16,20 | | | - City or To | | |
| Balti | permit. Departri imports ony inju | | | | | | | | | | | omes, 1536 | P.A. | |
| | - 1 | | 23a. Part1. Enter the disease, or comp shock, or heart ailure. List only | plications that caused the d | leath. Do not ent | er the mode of | dying, si | uch as ca | rdiac or respira | tory arrest, | | | Approximate Interval Betw | l Neen |
| | Physician | | Immediate Cause (Final disease or condition | Dom | ante a | i | | | | | | 1 | Onset and D | |
| 100 | /Medical Examiner | | resulting in death) | Due to (or as a con | sequence of): | | | | | | | - 3 | Jerry S | |
| ¥.,. | LXamilie | _ | Sequentially list conditions, | b | | | | | | | | | | |
| | pe #s | Examiner | Sequentially list conditions, Tany, leading to min adiato cause. Enter Underlying Cause (Disease or injury | Dualto (onde a eon | sequenes of); | | | | | | | | | |
| | icate be executed physicien and s the burial-transit | хап | that initiated events resulting in death) Last | c. Due to (or as a con: | sequence of\: | _ | | _ | | | | | | |
| 8760, | be e sicien buria | a E | | | 304001100 01). | | | | | | | | | |
| 687 | ficate phys s the | edicai | | d | | | | | | | | | | |
| Box (| eath certific ettending p for use as | J/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pre | gnancy | | | | | | 224 Da | ate of delive | | |
| 0 | the d the ched | Physician/M | in the past 12 months? 1 Yes 2 No 9 Unknown | 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time o 9 ☐ Unknown | | Ectopic pregna Other (specify | | | | _ | | | , | ear |
| ٩ | \$ 00 m | | Part II. Other significant conditions co | ontributing to death but not | resulting in the ur | iderlying cause | given in | Part I. | 23e. | Did tobacco | use con | tribute to th | e cause of de | ath? |
| Records | w requires been sign should be | ted by | | | | | | | _ | 1 ☐ Yes | 2240 | 3 🗌 Proba | ably 4 □Ur | nknown |
| ဝ | aw 1s b | Completed | | | | | _ | | | Was an autopsy | 24b. | Were autop | osy findings a | vailable |
| and the same of | Th ate pag | Con | | | | | | | 10 | performed? | ' | death? | npletion of ca 2□ No | u38 01 |
| Vital | ysician: Th is certificate director, pag | Be | 25. Was case referred to medical examiner? | | | | 26. | . Place of | Death (Check | | | | | |
| of | Physician: this certific ral director, | ည | 1 163 2010 | | ER/Outpatien | 3□ DOA | Other: 4 | □ Nursir | ng Home 5 🗆 | Residence | 6 □Oth | er (Specify |) | |
| | After Anner | lon | 27. Manner of Death Solution | 28a. Date of Injury (Month, Day Year | 28b. Time of Injury | | njury at Work? | | | cribe how in | jury occur | red | | |
| isic | or Attending after death. Director: After in by the fune | Icat | 2 Accident investigation 3 Suicide 6 Could not be | Dia Diana of Injury A | 1 hama (a | | | 2 🗆 No | | | | | | |
| É | after Dire | Certification: | 4 Homicide determined | 28e. Place of Injury - A building, etc. (Spe | ecify) | eat, lactory, on | ce | | City o | or Town, Sta | ana Numb ite) | oer or Hurai | Route Numb | θ/, |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer | edicai C | Check only 2 Medical Exam | vsician: To the best of my liner: On the basis of exam | knowledge, death | occurred at th | e time, d | ate and p | place, and due to | the cause | (s) and ma | anner as sta | ited. | |
| | vithin 2 | Med | one) 29b. Signature and title of certifier | and manner stated. | | | | | | | | | | |
| | 20 Wil | _ | 200. Signature and title of certifier | | | | ense nur | | , 1 | 29d. D | ate signe | d (Month, E | vay, Year) | |
| , | | | Whel Dave | A neo | e e | | 16 | 15 | 7 | 1 | | 14 | 100 | |
| | | 5 | 30. Name and address of person who c P. Daniel Miller, | | | , | l. Mr | ור ו | .550 | | 7/ | | | |
| 100 | Sta | te | 31. Date filed (Month, Day, Year) | 32. Registrar's Sig | | orrail0 | 1, 1,TF | , 21 | טפכ | | | | | |
| | Registr | | NOV 16 | 2006 | A. | Smarth 1 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

| | | | | State of | Maryland | - | rtificate | | Death | мена пу | rgiene Reg. No. 0 | 06 | 37862 |
|--------------------------------|--|-------------------------|---|---|----------------------------------|-------------------------------|--|--------------------|---|------------------------------------|---------------------------------------|-----------------|--|
| | Physic | ian | 1. Decedent's Name (First, Mi | ddle, Last) | | | | | | 2. Date of De | | | 3. Time of Death |
| | /Medi | | | | Galen Bee | eman | | | | Nove | mber 07, 2 | 2006 | 8:33 A.M. |
| ; س | Exami | ner | 4a. Facility Name (If not institu | | | | | 4 | b. City, Town, or | Location of Deat | h 4c. Coun | ty of Death | |
| - | C | | 5. Social Security Number | Egle Nursing | Home . Age <i>(In yrs. Is</i> | act hirthday | If Under 1 | Year | Lonac If Under 24 Hrs | | AL | | egany |
| | Funeral Director | | 219-03-8405 | 6. Sex 7 1 M 2 □ F | . Age (III yis. 18 | Yrs. | | Days | Hours Min. | (Month, Da | tn 1 <i>y, Year)</i> 7 21, 1920 | 9. Birthp | lace <i>(State or Foreign</i> htry) Maryland |
| | pu * | | Usual Residence of Decedent 10a. State 10b. Cour | | 10-00 | | | | | Julian | 21, 1920 | | |
| | daryla f sho | 5 | 200 | • | TOC. City | , Town or Lo | cation | | | | | 1 | 0d. Inside City Limits 1 Yes 2 No |
| | r 28e | rect | Maryland 10e. Street and Number | Allegany | | | 10f. Zip C | | Lonaconing | | 10g. Citizen of | What Coun | |
| | h with | Funeral Director | 5 | 7 Jackson Street | | | | | 21539 | | rog. Okizon of | U.S. | • |
| | r deal | ner | 11. Marital Status | 12. Was Deced | ent Ever in U,S | 3. 13. V | Vas Deceder | nt of Hi | spanic Origin? (S n, Mexican, Puert | pecify Yes or No | - 14. Ra | ce - Americ | an Indian, |
| Baltimore, Maryland 21215-0020 | d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "naturet" or itema 23a or 28e-f show treumatic event, the Medical Examiner must be notified at | þ | 1 ☐ Never Married 2 M M 3 ☐ Widowed 4 ☐ Divorc | arried 1 Yes 2 | □ No | | Yes 2,2 | | Specify: | o nican, etc.) | Speci | ack, White, i | etc. White |
| 15-(| "natu | Completed | 15. Deced (Specify only high | ent's Education hest grade completed) | | 16a. Deced (Give | ent's Usual (kind of work | Occupa done d | tion uring most of wor | king | 16b. Kind of E | Business/Inc | dustry |
| 12 | withir ene. than | m | Elementary/Secondary (0-12 | College (1-4 | or 5+) | life. L | OO NOT use | | | | | D | 3.4311 |
| 9 | filed Hygir Sther | | 17. Father's Name (First, Middle | | | | | | ipervisor 18. Mother's Nan | ne (First Middle | Maiden Surna | Paper | MIII |
| lan | lid be fental ked c | To Be | | George Edward | Beeman | | | | TO MOUTO O MAIN | | cretia Lou | -, | vn |
| lary | 2 should be filed with and Mental Hygiene. is marked other thar eumatic event, the M | - | 19a. Informant's Name/Relatio | | | 19b. Mailin | g Address (S | Street a | nd Number or Ru | | | | • |
| ≥, | Edila Marie (Miller) Beeman - Wile 1/314 New | | | | | | | | Memory L | ane, Lonac | oning, Ma | ryland, 2 | 21539 |
| Ö | of of or | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation | n 3 □Removal from Sta | 20b. Pla ce/ | nce of Dispos metery, crem | sition (Name natory or othe | of er place | 9) | Date November | 20c. Location | - City or To | wn, State |
| Him | + F 등 등 | | 4 ☐ Donation 5 ☐ Other | (Specify) | | | Hill Ce | | - | 10, 2006 | Mosco | w Mills | s, Maryland |
| Ba | permi Depa Impo any ir | | 21. Signature of Funeral Service | e Licensee | | 22. | Name and A | | Eichhorn-M | | | | |
| | | | 23a, Parti. Enter the disease. | or complications that cau | sed the death | Do not ente | ir the mode o | 8 | East Main S | Street, Long | aconing, M | ID 2153 | |
| | Physician | | 23a. Partil. Enter the disease, shock, or heart failure. Li | st only one cause on eac | h line. | Do not ente | i ille mode c | n uying | , such as cargiac | or respiratory a | rest, | 77 | Approximate Interval Between Onset and Death |
| 1 | /Medical | | Immediate Cause (Final disease or condition | A | dvano | red | T) | ر مو | · | | | 2 | 5 01 Venus |
| | Examiner | _ | resulting in death) | a | | as a consequ | ience of): | , | Dis | ~ | | | 7 (7) / 2013 |
| | ted | nine | | b | Al | ghei | mer ! | 5 | a dis | ease | | | |
| ~ | thet the death certificate be executed ed by the attending physician and detached for use as the buriel-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | Due to (or a | as a consequ | ience of): | | | | | | |
| 68760, | te be ysicla ne bur | | that initiated events | С | Due to (or a | s a consegu | ence off: | | | | | | |
| 89 3 | ntifica ng ph | Medical | resulting in death) Last | | 200 (0 (0) 2 | o a consequ | ence on. | | | | | | |
| Вох | ath ce | ian/ | | d | <u> </u> | | | | | | | | |
| P.0 | he de r the a | Physician/ | Part II. Other significant condit | | | | - | e giv <i>e</i> r | in Part I. | 23b. Did t | obacco use co | ntribute to | the ceuse of death? |
| σ. | | by Ph | Arterios | 5cleratie | he | avt | D | i 5 | ease, | 1 🗆 ነ | res 2□ No | 3 🗌 Proba | ably 4 Cinknown |
| rds | law requires thet the death ce as been signed by the attendi ? 2 should be detached for use | ed b | | | | | | | | 24a. Was | an autopsy | 24b. Wer | e autopsy findings |
| 000 | aw re as bee 2 sho | plet | | | | | | | | perfo | med? | com | lable prior to pletion of cause eath? |
| <u> </u> | The late has page | Completed | | | | | | | | 1 🗆 Y | es 2 No | 1 🗆 | Yes 2□ No |
| Vita | cian: sertific ector, | Be | 25. Was case referred to medic examiner? | | | | | | 26. Place of Deat | h (Check only o | ne) | | |
| o | Physi this c | ۴. | 1 ☐ Yes 2 No 27. Manner of Death | | atient 2 EF | | - Transmission | Other | 41 S Nursing Ho | me 5 Resid | | | |
| Division of Vital Records, | ding th. After fune | ţi | 1 Natural 5 ☐ Pend | ing 28a. Date of Ir (Month, I | Day Year) | 8b. Time of Injury | M 28C. | Injury a Work? | es 2 🗆 No | 28d. Describe h | ow injury occuri | red | |
| visi | Atten er dea ector. by the | Certification: | 3 ☐ Suicide 6 ☐ Could | not be 28e. Place of | Injury - At hom | e, farm, stree | | | | 28f. Location (S | treet and Numb | er or Rural i | Route Number, |
| ۵ | tal or rs afte al Dir led in | Ser | 4 I Homicide | building, | etc. (Specify) | | | | | City or Tow | n, State) | | |
| | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2 | edical | 29a. Certifier 1 Certifyi (Check only one) 2 Medica | ng Physician: To the best I Exeminer: On the basis and manner | or examination | edge, death on and/or inve | occurred at the stigation, in a | ne time my opir | , date and place, nion, death occurr | and due to the cred at the time, c | ause(s) and ma ate and place, a | inner as stated | ted. he cause(s) |
| | Vit To T | Σ | 29b. Signature and title of certifi | er C | 11 | | 29c. Li | | | | 9d. Date signed | | |
| | | - | 30. Name and address of persor | who completed cause of | f death (Item ?) | Sa) (Tuno D | rint) | 1 7 | 1464 | | Nov. | 5, 2 | 006 |
| 5 | +VA | | S.L SANUL | | 48 TA | co T | nii) - A.A.A.F A | | Frestbur | o Mar | lund. | 2/1 | 32 |
| | Stat | | 31. Date filed (Month, Day, Year |) 32. Regis | strar's Signatur | е . | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 1 | 7 - 2 - 2 | 11 111 | MULK | 0.12 | |
| | Registra | | | 2000 | Cres d | J. A | model 1 | | | | | | |
| DHI | MH 16 Rev 6/95 | | | | | | | | | | | | |

| | | | 1 - For Amend #26 pe | State of Maryland r FH/PHYS 11- | ا / Depa 14 -2 0 | artment of H | ealth and Death | Mental Hyg | iene 0 0 1 | 5 37863 |
|----------------|--|---------------------|---|--|--------------------------------|---|-------------------------------------|---|------------------------------------|--|
| | Dhyciai | | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of Deat Month | Day Y | 3. Time of Death |
| | Physicia /Medic | al . | PETER | | BER | ZONSKY | 1 | | R 5, 200 | |
| | Examin | er | 4a. Facility Name (If not institution, give st | | | 4b. City, Town, or | | ith | 4c. County of | erick |
| , ×, | | | Homewood at Crumla 5. Social Security Number 6. Sex | 7. Age (In yrs. Ia | st birthday) | Frede | If Under 24 Hr | s. 8. Date of Birth | 9 | . Birthplace (State or Foreign |
| * | Funeral Director | | | w 2□F 87 | Yrs. | Months Days | Hours Mir | June 24 | ,1919 I | Pennsylvania |
| | pu sea | | Usual Residence of Decedent 10a. State 10b. County | 10c City | , Town or La | cation | | | | 10d. Inside City Limits |
| | shov | 5 | Maryland Freder | | Frede | | | | | 1∭Yes 2☐No |
| | 28a-f | rect | 10e. Street and Number | ICK | rrede | 10f. Zip Code | | 1 | 0g. Citizen of Wh | at Country? |
| | 3a or | 0 | 7401 Willow Rd., | <i>#</i> 212 | | 2170 | 2 | | United | States |
| 21215-0036 | be filed within 72 hours after death with the Maryland ital Hyglene. d other then "naturel", or items 23a or 28s-f show event, I're Medical Examinar routike notified at | by Funeral Director | 11. Marital Status 11. Marital Status 12. Married 2. Married 3. Widowed 4. Divorced 11. | 2. Was Decedent Ever in U.S Amed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1941—4 | - | Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 🗓 No | | Specify Yes or No- irto Rican, etc.) | | American Indian, White, etc. White |
| 2 | 72 ho | eted | 15. Decedent's Education (Specify only highest grade | ation completed) | 16a. Dece | dent's Usual Occupa kind of work done of DO NOT use retired | ation furing most of w | orking | 16b. Kind of Busi | ness/Industry |
| 21 | ithin 16 | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | | | | | | |
| 121 | filed w Hygier other th | | 12 17. Father's Name (First, Middle, Last) | | Sheet | Metal Cr | | ame (First, Middle, | | ernment |
| anc | should be filed within nd Mental Hygiene. marked other then umatic event, in a Mental control of the Mental co | Be | Wasco | Berzonsky | | | Fann | | Pollacl | τ. |
| Maryland | s 1 and 2 should f Health and Men item 27 is marke other traumatic | ို | 19a. Informant's Name/Relationship (Typ | | 19b. Maili | ng Address (Street a | | Rural Route Number | | |
| | and 2 salth ar | | Alma Berzonsky / I | Wife | 7401 | Willow Rd | 1., #212 | | | yland 21702 |
| Baltimore, | of Hear of Hear fitem | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re | Ce Ce | ace of Dispo ametery, crea | sition (Name of matory or other place | е) | Date | 20c. Location - Ci | ty or Town, State |
| Ĕ | permit. Pages of Depertment of Important: If ite eny injury or of once. | | 4 □Donation 5 ☒ Other (Specify) | | int 01 | ivet Cem. | | | | ,Maryland |
| 3alt | Depertiment Import | | 21. Signature of Funeral Service License | 151 | | | | tauffer F | | |
| | 20200 | | 23a, Part 1. Enter the disease, or complic | Jellus | | - | | Pike/ Fre | | Approximate |
| | Physician /Medical | | shock, or beart failure. List only one Immediate Cause (Final disease or condition resulting in death) | e cause on each line. Pheun | non | | 9, 30011 20 32 31 | ao or rospirator, arr | | Interval Between Onset and Death 3-5 Dowy |
| I | Examiner | | | Due to (or as a consequ | ence ot): | | | | | |
| | | ler | Sequentially list conditions, in any, leading to immediate cause. Enter Underlying | Due to (or as a nonsequ | ienna if): | | | | | |
| | ate be executed hysicien end he burial-transit | Examin | that initiated events c. | | | | | | | |
| o, | te be executed ysicien end le burial-transit | | resulting in death) Last | Due to (or as a consequ | ience of): | | | | | |
| 68760, | ate be hysici the bu | lical | d. | | | | | | | - |
| x 6 | death certifica e attending ph ed for use as th | Physician/Med | IF FEMALE: 23 | ic. If yes, outcome of pregnar | ncv | | | | 23d. Date | of delivery |
| Вох | atten for us | clan | in the past 12 months? | 1 Live birth 2 Fetal 4 Pregnant at time of de | death 3[| Ectopic pregnancy Other (specify) | | | Monti | · · · · · · · · · · · · · · · · · · · |
| 0 | at the de by the i | hysi | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□ Unknown | | | | | | |
| rds, P | signed be de | þ | Part II. Other significant conditions conditions | ributing to death but not result | | inderlying cause give | en in Part I. | 23e. Did to | _/ | ute to the cause of death? |
| Vital Record | law reques been 2 shoul | Completed | | | | | | 24a. Was a | an 24b. We | ere autopsy findings available or to completion of cause of |
| Ä | | ĕ | | | | | | perfor | | ath?] Yes 2 🗌 No |
| /ita | ician: Th certificate rector, pag | Be (| 25. Was case referred to medical examiner? | | | Oth | | eath (Check only or | 76) | |
| of \ | Phys this al dii | -T | 1 ☐ Yes 2 ☑ No | ospital: 1 Inpatient 2 I | ER/Outpatie | | 4 Nursing | | ence 6 Other ow injury occurred | |
| no | Jing After fune | For | 1 Natural 5 Pending | 28a. Date of Injury (Month, Day Year) | Injury | Wor | k?` Yes 2 □ No | 200. 2000 | o | |
| Division | or Attending after death. Director: After in by the fune | Certification: | 3 Suicide 6 Could not be | 28e. Place of Injury - At ho | me, farm, st | reet, factory, office | | | | or Rural Route Number, |
| ē | - e = c | Serti | 4 Homicide | building, etc. (Specify | ′) | | | City or Tow | n, State) | |
| | To the Hospital c within 24 hours af To the Funerel D completely filled in | edical (| 29a. Certifier 1 Certifying Thys (Check only one) 1 Medical Examin | er: On the basis of examinat and manner stated. | wladge, dat tion and/or in | h contined at the tin exestigation, in my o | ne date and pla pinion, death oc | curred at the time, of | date and place, an | d due to the cause(s) |
| | To th withir To th comp | Me | 29b. Signature and title of certifier | | | 29c. Licens | | | = | (Month, Day, Year) |
| 1 | A. | | 1 | tiven N Si | hoh | mo D | 51-64. | 3- | 11.6.0 | 6 |
| \ | 4/11. | | 30. Name and address of person who co | mpleted cause of death (Item | 23a) (Type | , Print) | | 3. MO | 00 - | |
| 1 | M. | 76 | 31. Date filed (Month, Day, Year) | 22. Restrar's Signa | ture 68 | | enc/s | MO " | 4 +0 2 | |
| and the second | St Regist | ate rar | NOV 1 4 2 | 006 Alleger | K, | book | | | | |

Please Type or Print in Black Indelible Ink

| John Wallace Brown | n S | State of Maryla | | | Health an | | Hygiene | 21 | 006 3786 | | | | |
|--|--|---|--|--------------------------------------|-----------------------------------|-------------------------------------|--|--|---|--|--|--|--|
| Dhysician | Registrar 1. Decedent's Name (First, Mid | Idle Last) | Cer | incate of | Dealli | | 2. Date of Dea | teg No. | 3. Time of Death | | | | |
| Physician/ Medical Examiner | John W. Brown | ı | | | | | Month Novembe | Day Year er 20, 2006 | 1730 hrs | | | | |
| Production of the second | 4a. Facility Name (if not instituted) Wallace Road @ De | | mber) | 4 | b. City, Town, or Salisbury | · Location of De | eath | 4c. County o Wicomic | | | | | |
| Funeral | 5. Social Security Number | 6. Sex | 7. Age (In yrs. la | ast birthday) | If Under 1 Yea | | | irth(MM/DD/YYYY) | | | | | |
| Director | 214-32-6076 | 1 X M 2 F | 71 | Yrs. | Months Day | s Hours 1 | Jan 2 | 3, 1935 | Foreign Country) MD | | | | |
| | Usual Residence of Decedent | <u>'</u> | Lea de la constante de la cons | | | | | | Land Indian On Compa | | | | |
| w any | 10a. State 10b. Count | • | | Town or Location | on | | | | 10d Inside City Limits 1 X Yes 2 No | | | | |
| uryland Sa-f sho at once, | MD Wico | omico | Sa | lisbury | 10f. Zip Code | | T | 10g. Citizen of Wh | | | | | |
| uit the Maryland 23a or 28a-f show uotified at once, al Director | 412 Robinson S | Stroot | | | 2180 | 1 | | USA | | | | | |
| vith th | 11. Marital Status | | edent Ever in U. | S. 13. Was | | | (Specify Yes or N | | - American Indian, Black, | | | | |
| or items 23 must be no Funeral | | Married Armed Fo | orces? | | s, specify Cuba | | | White | | | | | |
| safter d | 3 Widowed 4 C | ivorced If Yes, Give Yea | | 1 | Yes 2 X No | specify: | | Specify: E | Black | | | | |
| natura xami | 15. Decedent's Education (Sp | pecify only highest grad | | | s Usual Occupa | | | 16b. Kind of Bus | siness/Industry | | | | |
| 5-0036 ed within 72 hour tygiene. other than "natu the Medical Exa | Elementary/Secondary (0-12 | 2) College (1 | -4 or 5+) | | | | • | Pos | + | | | | |
| 5-0036 led within 7 Hygiene. I other than the Medica | 12 17. Father's Name (First, Midd | le Last) | | | Cool | | me (First, Middle, | Maiden Surname) | Restaurant | | | | |
| 215- be filed triked of riked of ent, the | Vernon Brown | , | | | | Marv | Dashiell | , | | | | | |
| 213 ould b d Meni s mark tic eve | 19a Informant's Name/Relation | nship (Type, Print) | | 19b. Mailing | Address (Street | | | mber, City or Town | n, State, Zip Code) | | | | |
| MD d 2 sha lth and 17 is sumat | Joslin Brown/v | vife | | | | | | , MD 2180 | | | | | |
| | | | | | | Date | 20c. Location - | City or Town, State | | | | | |
| imo Page nent ciant: or oth | 4 Donation 5 Other | Specify: | Ve | terans | Cemeter | | /27/2006 | Hurloc | ck, MD | | | | |
| Baltimore, permit. Pages I an Oppartment of He Important: If ite injury or other tr | 21. Signature of Funeral Service | ce Licensee | | 22. N | me and Addres | s of Facility Natson_: | Funeral 1 | Home , MD 2180 | 14 | | | | |
| | 23a. Part I. Enter the disease, | or complications that ca | aused the death. | Do not enter th | 18 West e mode of dving | Rd., S | allsbury ac or respiratory ar | rest, shock, or hea | rt Approximate Interval | | | | |
| Physician /Medical | failure. List only one caus | se on each line. | | | | | | complicated | Between Onset and | | | | |
| Examiner | Immediate Cause (Final diseas or condition resulting in death) | Due to (or as a | consequence of | Hyperthe | ermia an! | drowning | i disease (| 7 III, TTCALEG | Dy | | | | |
| ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | | consequence of | f): | | | | | | | | | |
| ed nsit Examiner | (Disease or injury that initiated events resulting in death) Las | C. | consequence of | t). | | | | | - | | | | |
| | | d | | | . <u> </u> | | | | | | | | |
| 0, e be execu rsician and burial - tra | X UNPENDED | AMENDED | | | rME, g862 | 2, 12/5/0 | 5 TT | 22d Data of | dolivor | | | | |
| of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate better this certificate has been signed by the attending physitumeral director, page 2 should be detached for use as the bun. To Be Completed by Physician/Mec | IF FEMALE: 23b. Was decedent pregnant in past 12 months? | | outcome of pregi irth | | al death 3 | Ectopic pre | gnancy | 23d. Date of o Month | Day Year | | | | |
| Ox 6 ath cer attendi or use | 1 Yes 2 No 9 U | Interesting | ant at time of de | ath 5 Oth | er (Specify) | | | | | | | | |
| b. Box the death con the attention of th | Part II. Other significant cond | 3 JOHNHO | | sculting in the u | nderlying cause | given in Part I | 23e Did i | tobacco use contrib | oute to the cause of death? | | | | |
| P.O. ss that to gened by e detac | | anona contributing to | J death but hot re | ssaining in the di | idenying cause | given in react. | | es 2 V No 3 | | | | | |
| (ecords, The law requires are has been sig age 2 should be | | | | | | | 24a. Was | | Vere autopsy findings available | | | | |
| COL law r has b e 2 sh mple | | - | | | | | | ormed? de | rior to completion of cause of eath? | | | | |
| Re : The ifficate r, pag | 25. Was case referred to medi | <u></u> | | | 26 Plac | e of Death (Che | 1 Yes | 2 No 1 | Yes 2 No | | | | |
| Vital ysician his cert directo | examiner? | Hospital: | Inpatient 2 | ER/Outpatient | | Other | rsing Home 5 | Residence 6 | Other: Scene | | | | |
| n of Vital Records, ding Physician: The law requit After this certificate has been s funeral director, page 2 should on: To Be Completed | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Date | of Injury | 28b. Time of Ir | jury 28c. Inju | ury at Work? | | how injury occurre | | | | | |
| The second of th | | | | | | Yes 2 No | cold wea | | on pond during | | | | |
| Natural 5 Pending Investigation 2 See. Place of Injury - At home, farm, st of Death of Least 1 See. Place of Injury - At home, farm, st of Death of Least 1 See. Place of Injury - At home, farm, st of Death of Least 1 See. Place of Injury - At home, farm, st of Death of Least 1 See. Place of Injury - At home, farm, st of Death of Least 1 See. Place of Injury - At home, farm, st of Death of Least 1 See. Place of Injury - At home, farm, st of Death of Least 1 See. Place of Injury - At home, farm, st of Death of Least 1 See. Place of Injury - At home, farm, st of Death of Deat | | | | | | building, etc. | 28f. Location | Street and Numbe | er or Rural Route Number, City e Rd. @ Delamar Dur | | | | |
| Spital Di | 4 Homicide | termined (Specify) | | tion pond | | | Salisbur | y, MD | | | | | |
| Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director, Medical Certification: To Be (| 29a Certifier 1 Certifying one) 2 Medical E | Physician: To the best xaminer: On the basis | of examination a | ge, death occur nd/or investigati | ed at the time, on, in my opinion | date and place, n, death occurre | and due to the cau ed at the time, date | ise(s) and manner and place, and du | as started. ue to the cause(s) | | | | |
| To To COL | 29b. Signature and title of cert | and manner s | rialeu. | | 29c. Licen | se number | | 29d. Date signe | ed (Month, Day, Year) | | | | |
| | (101 M C | of HA | e Va | u | 0.0 | M.E. | | November 2 | 21, 2006 | | | | |
| | 30. Name and address of pers | | | | | | 204 | i | | | | | |
| | | Assistant Medical | Examiner Sstrar's Signatu | | Street, Baltim | iore, IVID 21 | 201 | | | | | | |
| State Registra | | 7 2006 | Udus J | & So | and I | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month V Sandra Lee Brumbley 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISPUL If Under 1 Year | If Under 24 Hrs rs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Year) 1 □ M 2**K** F 216-48-6157 60 5/7/1946 **Director** Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norified as once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1247 Middleneck Drive 21804 USA Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11, Marital Status Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calvin Brumbley Beulah Staton ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dee A. Bolen/sister 1247 Middleneck Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Parsons Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/13/06 Salisbury, MD 21. Signature of Funeral Service Lice THOTISWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Kleiner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 🗌 Yes 2 No 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Tes 2 No Certification: To 1. Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☑ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Lacrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Salisbury Md Douglas B. WIThite MD 100 E. CARROLL 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV Registrar 2006

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 37866 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Johnny Barrett November 17, 2006 4c. County of Death 7:00P Sr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4306 Sheldon Avenue 7. Age (In yrs. last birthday) Temple Hills
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Prince e Georges
9. Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months 11**2** M 2□ F Yrs. Director 246-80-9402 56 Feb.5. 1950 NC Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or itema 23a or 28e-f ahow traumatic avant, the Macinal Exemiter mate to notified at Director 1 ☑ Yes 2 ☐ No MD. PG Temple Hills 10e. Street and Number 10g. Citizen of What Country? 4306 Sheldon Avenue Completed by Funeral 20748 United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 NYes 2 No 1969 -1 ☐ Never Married 2 Married Specify: Black 1 ☐ Yes 2€ No 3 ☐ Widowed 4 ☐ Divorced 1975 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Government <u> Air Marshall</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roland Barrett Johnie Bethea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4306 Sheldon Avenue Temple Hills, Md. 20748 Elva Barrett/wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ♀ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md. Veterans Cem. 11/27/06 Cheltenham, Md. 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. B910 Silver Hill Rd., Suitland, Md. 20746 232. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Invenediate Cause (Final **Physician** disease or condition resulting in death) Congestive Heart Failure 2 Weeks /Medical Due to (or as a consequence of): Examiner Hypertension >10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Scleroderma >5 years that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Year Month P.O. I 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? certificate 1 Yes 2X No Hospital or Attending Physician: After this certification, funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐XNo 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 SNatural 2 ☐ Accident 5 Pending death. investigation 1 Yes 2 No after death Director: the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funerel C completely filled i 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sii C. Marshall MD33102 November 21, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3+1 Eric C. Marshall, M.D. 1160 Varnum St., NE, Suite 117, Wash., DC 20017
31. Date filed (Month, Day, Year)
32. Registra's Signature, S State Registrar

| | | | 1 - For State Registrar | State of Ma | ryland / Depa <i>Ce</i> | artment of F | lealth and <i>Death</i> | | gien 2 0 0 6 | 37867 |
|-----------------|--|-------------------|--|--|--|--|--|---|--|---|
| | Physic | ian | Decedent's Name (First, Middle, L. | | | <u>-</u> - | | 2. Date of Dea | | 3. Time of Death |
| | /Medi | | Leonard | Oliver | Bible | | | Nov 18 | 3, 2006 | 2130 ^M |
| 1 | Exami | ner | 4a. Facility Name (If not institution, g Memorial Hospit | al | | Cumbe | | | 4c. County of Dea | • |
| | Funeral Director | | 218-16-4394 | Sex 7. Age 1 | (In yrs. last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs Hours Min | | Year) 9. Bii | rthplace (State or Foreign ountry) |
| | yend w | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or Lo | cation | | | | 10d. Inside City Limits |
| | r 28e-f ehow | ctor | MD Allega | any | Cum | berland | | | | 1 ☐ Yes 2 ☐ No |
| | th with th | Funeral Director | 13002 Moores Ho | ollow Road | | 10f. Zip Code | 21502 | 1 | 0g. Citizen of What C | ountry? |
| | death | ner | 11. Marital Status | 12. Was Decedent Ev Armed Forces? | er in U.S. 13. | Was Decedent of H | | Specify Yes or No- to Rican, etc.) | USA 14. Race - Amo | |
| 21215-0036 | hours after death with the Merylend turel; or items 23e or 28e-f show al Examinar must be notified at | Þ | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 NYes 2 No | | 1 Tes, specify Cuba 1 ☐ Yes 2 🗷 No | Specify: | to Hican, etc.) | Black, Whi | nite |
| 5-0 | 2 24 | Completed | 15. Decedent's E (Specify only highest gi | | 16a. Deced | tent's Usual Occup | ation | deina | 16b. Kind of Business | |
| 121 | d within piene. rrthen " | mpi | Elementary/Secondary (0-12) | College (1-4or 5+) | | kind of work done o | d) | 'All'Ig | | |
| | | ပိ | 17. Father's Name (First, Middle, Las | 0 | Calend | dar Dept. | 18 Mother's Na | me (First, Middle, M | Tire Co. | |
| Maryland | ges 1 and 2 should be filed vit of Heelth and Mental Hygis if I tem 27 is marked other or other treumatic event, IL | To Be | Russell Bible | | | | Pearl | (May) Bibl | le | |
| | eith and 27 is n | | 19a. Informant's Name/Relationship Margaret Bible | (Type, Print) Wife | 19b. Mailin 1300 | g Address <i>(Street a</i> D2 Moores | and Number or Ru Hollow | ural Route Number, Rd Cumbe | City or Town, State, A | Zip Code) 1D 21502 |
| ore, | of He m | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [| Pomoval from State | 20b. Place of Dispo- cemetery, cren | | | | 20c. Location - City or | |
| Baltimore, | 4 4 6 6 | | *4 ☐ Donation 5 ☐ Other (Speci | fy) | Mt. Hermon | Cemetery | | 11/22/2006 | Cumberlar | nd MD |
| Ba | permit. Depertm Importer any Injur | | 21. Signature of Funeral Service Lice | LA IQU | 22 | Name and Address Scarpell 108 Viro | is of Facility i Funeral H | lome, PA | and, MD 2150 | 00 |
| | /Medical Examiner buyaician and physician and the buriai transit the buriai transit | Examiner | 23a. Part1. Enter the disease or constock, or heart failure. Ust only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influsy that initiated events resulting in death) Last | a. Due to for an a | onsequence of): | inforce | tim | | J., | Approximate Interval Between Onset and Death |
| P.O. Box 68760, | t the death certifi by the ettending ached for use as | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | _dd | Fetel death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of deli Month | ivery Day Year |
| | quires the n signed uid be det | 全 | Part II. Other significant conditions (| contributing to death but n | ot resulting in the un | derlying cause give | n in Part I. | | acco use contribute to | the cause of death? |
| Vital Records, | The page | Completed | | | | | | 24a. Was an autopsy performs | ed? death? | topsy findings available completion of cause of |
| <u>=</u> | ilcien: certific rector, | 00 | 25. Was case referred to medical examiner? | Hospital: | Wester | 011 | | th (Check only one, |) | |
| * | ling Phye | lon; To | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending | 28a. Date of Injury (Month, Day Ye | 2 ER/Outpatient 28b. Time of Injury | 28c. Injury Work | at ? | ome 5 ☐ Residen 28d. Describe how | ce 6 Other (Spec vinjury occurred | ify) |
| Division | To the Hospital or Attending P within 24 hours efter deeth. To the Funeral Director: After to completely filled in by the funeral | Certification; | 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined | 1 . | - At home, farm, stree Specify) | | es 2 □No | 28f. Location (Stre City or Town, | et and Number or Rui State) | ral Route Number, |
| | re Hospit 24 hour e Funera letely fills | ledical C | 29a. Certifier (Check only one) 1 - Certifying Ph 2 Medical Example 1 | ysician: To the best of m niner: On the basis of exa and manner stated | amination and/or inve | occurred at the time estigation, in my op | e, date and place, inion, death occur | and due to the cau red at the time, date | rse(s) and manner as e and place, and due | stated. to the cause(s) |
| | within To th comp | | 29b. Signature and title of certifier | | | 29c. License | number | 290 | d. Date signed (Month) | , Day, Year) |
| | | |) She | lew 20 | | Do | 017565 | | how, 20, 2 | -006 |
| + | 4 | | 30. Name and address of person who | completed cause of death | (Item 23a) (Type, P | rint) | 6-11 | 11 | 1 21504 | |
| | Star Registra | .0 | 31. Date filed (Month, Day, Year) | 32 gegistrar's | Signature | will . | | | 1 2/56- | |

| | | | For State Registrar | | State of M | larylar | | artment of rtificate o | | | lental Hy | • | 2001 | <i>-</i> | 37868 |
|--------------------------------|---|---|--|--|--|------------------------------------|------------------------|--|-----------------|--------------------|-------------------------------------|-------------------------|-----------------------------|-----------------------------|---|
| 100 | e d | | Decedent's Name (First, Middle, Last) | | | | | | | 1 | 2. Date of De | Reg. No | 200 | | . Time of Death |
| | Physic | | Evelvn 1 | Louise Ba | ldwin | | | | | | Month Novemb | Da | , | r | |
| | /Medi Exami | | | | e street and number | ·) | | 4b. City, Town | , or Location | n of Death | NOVEMD | | . County of De | | 9:15 A [™] |
| 1 | | | Ravenwoo | od Luther | an Villag | e | | Hagers | town | | | Ti | ashing | ton | |
| 0.5 | Funeral | | 5. Social Security N | | | ge (In yrs. | last birthday) | If Under 1 Ye Months Day | ar If Unde | er 24 Hrs. Min. | 8. Date of Bi | rth | 0.5 | Birthplace | (State or Foreign |
| п | Director | | 197-22-05 | 0/2 | 1□M 2□XF | 90 | Yrs. | Working Day | S Hours | IVIIII. | 3/3/19 | 16 | Ma | Couintry) L ryl a | and |
| | and w | | Usual Residence of 10a. State | f Decedent 10b. County | | 10c Cit | ty, Town or Lo | cation | | | | | | 40.1 | |
| | farylarylarylarylarylarylarylarylarylaryl | ē | MD | Washing | rton | 100.01 | • | | m | | | | | | Inside City Limits TV☐Yes 2☐No |
| | the A | Director | 10e. Street and Nu | | 30011 | | 110 | gerstow 10f. Zip Code | | | | 10- 0 | V | | ** |
| | with Sa or t be r | Ö | | her Drive | a | | | | 740 | | ĺ | iog. Cil | tizen of What o | Country? | |
| | ms 2; | Funeral | 11. Marital Status | IICI DIIV | 12. Was Deceden | t Ever in U | .S. 13. 1 | | | Origin? (Spe | ecify Yes or No |)- | 14. Race - Ar | nerican li | ndian. |
| 9600 | filed within 72 hours after death with the Maryland Hygiene. ther than "natural"; or items 23a or 28a-f show ont, the Medical Examiner must be notified at | by | | ied 2 Married 4 Divorced | Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: | [No | | Was Decedent of If Yes, specify C 1 □ Yes 2X N | | | Rican, etc.) | | Black, Wi Wh Specify: | | , |
| 5-0 | 72 h 'natu dical | etec | (Spec | 15. Decedent's E | ducation ade completed) | | 16a. Dece | dent's Usual Occ | upation | ast of worki | na | 16b. K | ind of Busines | s/Industr | гу |
| 2121 | filed within Hygiene. other than " | Completed | Elementary/Second 10 | ondary (0-12) | College (1-4or | 5+) | | kind of work doi DO NOT use reti emaker | | | | | Own Hom | e | |
| Baltimore, Maryland 21215-0036 | iges 1 and 2 should be filed it of Health and Mental Hygi If Item 27 Is marked other or other traumatic event, ti | To Be | 17. Father's Name Delmar T | | ·) | | | | 18. Moti Ann | nie Ma nie Ma | (First, Middle ary Nor | , Maiden ris | Surname) | | |
| lar | 2 sho | | 19a. Informant's Na | | | | | g Address (Stre | | | | | | | i i |
| a) | l and lealth im 27 ther to | Robert D. Kline/Nephew 85 New Bridgeville R 20a. Method of Disposition 20b. Place of Disposition (Name of cameter, gramatory or other place) | | | | | | | | | | | | | 17368 |
| imor | Pages 'ment of Hant: If Ite | | 1⊠ Burial 2 4□Donation | □Cremation 3 □ 5 □ Other (<i>Speci</i> | _ | . 4 | cemetery, crer | sition (Name of natory or other p ge Ceme | | | 5/2006 | | elta, P | | State |
| Balt | Slate Ridge Cemetery, ciematory or other place) 1 | | | | | | | | | | ., E | | | | |
| | Physician /Medical Examiner | | Immediate Cause (disease or conditio resulting in death) | (Final n | olications that cause one cause on each l | no va | sculo | er the mode of d | | | | rrest, | | Inte On: | proximate erval Between set and Death |
| 0, | ficate be executed physician and is the burial-transit | Examiner | Sequentially list co- if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) I | rlying injury | cDue to (or as | | | | | | | | | | |
| x 68760, | | /Medical | IF FEMALE: | | d. | | | | | 77) | | _ | | | |
| P.O. Box | that the death certified by the attending detached for use as | Physician/M | in the past 12 1 Yes 2 9 Unknown | months? | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown | 2 Feta | Ideath 3 □ | Ectopic pregnar Other (specify) | су | | | | 23d. Date of d Month | elivery Day | Year |
| | w requires that the de been signed by the a should be detached f | þ | Part II. Other signif | icent conditions | ontributing to death t | out not resi | ulting in the ur | deriying cause o | iven in Part | I. | | obacco u Yes 2[| se contribute ☐ No 3 ☐ F | to the ca | use of death? |
| Division or Vital Records, | The law ate has b | Completed | | | | _ | _ | | | | 24a. Was autor perfo 1 Yes | | prior to | complet | indings available tion of cause of |
| /ita | stan: ertific ctor, | Be | 25. Was case reference examiner? | red to medical | | | | | 26. Plac | e of Death | (Check only o | - | 1010 | | 140 |
| 7 | Physiclan: r this certific ral director, | 2 | 1 ☐ Yes 2 | No | Hospital: 1 ☐ Inpati | ent 2 | ER/Outpatient | 3 DOA O | ther: 4 N | lursing Hon | ne 5 🗆 Resid | dence (| 6 □Other (Sp | ecify) | |
| П | ng P | | 27. Manner of Death | h 5 ∐ Pending | 28a. Date of Inju (Month, Da | | 28b. Time of Injury | 28c. Inj | | | 8d. Describe I | - | | | |
| sio | tendleath. | cati | 2 ☐ Accident 3 ☐ Suicide | investigation 6 ☐ Could not be | | | | |]Yes 2 [|]No | | | | | |
| Divi | tal or At s after d al Direct ed in by | Certification: | 4 Homicide | determined | 28e. Place of in building, e | ury - At ho c. <i>(Specif</i>) | me, farm, stre | et, factory, office | 9 | 2 | 8f. Location (S City or Tox | Street and vn, State | d Number or F) | Rural Rou | ite Number, |
| | To the Hospital or Attending Physically within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors. | Medical | 29a. Certifier (Check only one) | | ysician: To the best niner: On the basis o and manner st | | | | | | | | | | |
| | To t To 1 | Σ | 29b. Signature and | title of certifier | 1. 11. 21 | | | 29c. Licer | ise number | | | 29d. Dat | e signed (Mor | th, Day, | Year) |
| | | | > che | man (| 1/8/09 |) | | 02 | 5365 | | | 11- | 20-01 | • | |
| _ | 10 | | 30. Name and addre | ess of person who | completed cause of c | leath (Item | 23a) (Type, F | erint) Stra | ul- | Hes | Zesten | m | 190 | 121 | 740 |
| Ī | Sta Registr | | 31. Date filed (Mont | n, Day, Year) OV 2 9 21 | 32 Registr | rar's Signa | ture for | will be | | (| , | | | | |

| | laryland / Departm | nt in Black Indelible Ink ent of Health and Mental H ate of Death | ygiene Reg. No | 200 | 6 37870 |
|----------------|--------------------|---|---|--------------------|------------------------------|
| le,Last) | William | Beard | 2. Date of Death Month Day November 18, | Year 2006 | 3. Time of Death 0625 hrs |
| n, give street | and number) | 4b. City, Town, or Location of Death Cumberland | | c. County of Deatl | |

| | | 1- For State Registrar | | ertificate o | f Death | | | Reg. N | 10. Zl | JU | 5 3/8/ |
|---|---|---|--|----------------------------------|-----------------------------|-------------------------|---|------------------------|----------------------|-----------|---|
| Physician/ 1. Decedent's Name (First, Middle,Last) | | | William | | Beard | | 2. Date of D Month Novemi | Death Day ber 18 | y Year 3, 2006 | | 3. Time of Death 0625 hrs |
| | | 4a Facility Name (if not institution 14300 McMullen Hwy | i, give street and number) | | 4b. City, Town, Cumberla | | f Death | | 4c. County o | | |
| Funeral | | | 6. Sex 7. Age (In yrs. | last birthday) | If Under 1 Y | | r 24Hrs. 8. Date of | Birth (M | , | | thplace (State or |
| Director | | 217-66-9795 Usual Residence of Decedent | 1XM 2F 49 | Yrs | Months D | ays Hours | | | | Foreig | in Maryland untry) |
| any | | 10a. State 10b. County | 10c. City | , Town or Local | tion | | | | | | 10d. Inside City Limits |
| * | | MD A1 | llegany | Cu | mberlan | d | | | | | 1 X Yes 2 No |
| Maryland 28a-f show datonce. | Director | 10e. Street and Number | | | 10f. Zip Code |) | | 10g C | Citizen of Wha | at Cour | |
| ith the M 23a or 2 notified | | 405 Oldt | town Road | | 21 | 502 | | | USA | | |
| death w or items | Funeral | 11. Marital Status 1 Never Married 2 X Ma | 11 X Yes 2 No | If Y | es, specify Cub | oan, Mexican, I | in? (Specify Yes or Puerto Rican, etc.) | No- | 14. Race - White, | | can Indian, Black, |
| ors afte tural" | þ | | orced if Yes, Give Year 1976— or Dates: offy only highest grade completed) | | | | ind of work done | Tich | Specify: | _ | ite |
| 72 hou | Completed | Elementary/Secondary (0-12) | College (1-4 or 5+) | during m | nost of working li | ife. DO NOT u | use retired) | 160 | . Kind of Bus | iness/ir | ndustry |
| 036 rithin ane. rr than | ğ | 12 | | Own | er and | Operat | or | | Floor | ing | |
| 5-0 iled w Hygic d othe | | 17. Father's Name (First, Middle, I | , | <u></u> | | | s Name (First, Middle | e, Maide | | | |
| 21215-0036 vuld be filed within 7 Mental Hygiene. marked other than c event, the Medica | o Be | Bernard 19a. Informant's Name/Relationsh | Eugene | Beard, | | Mai | ry Ca | ther | rine | Sf | tegmaier |
| MD 2 d 2 shoul lth and N n 27 is m | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Start Susan K. Beard / wife 405 Oldtown Road, Cumberland, Marylar | | | | | | | | State, | Zip Code) | |
| e, N I and I Health item I | | 20a. Method of Disposition | 20b. I | Place of Dispos | ition (Name of c | | Date | | c. Location - (| | |
| The standard of Disposition of Standard of Disposition The standard of Disposition of Standard of Disposition of | | | | | | | | | tet. | one MD | |
| Baltir permit P Departme Importar | | 21. Signature of Funeral Service L | | | | | | | | | Home, P.A. |
| o §°a ii | | Kirkent Co | adean | 4 (| 04 Decai | tur Str | reet. Cum | berl | land. N | MD | 21502 |
| Physician /Medical | | 23a Part I. Enter the disease, or c failure. List only one cause o | complications that caused the death. on each line. | . Do not enter th | ne mode of dyin | g, such as car | rdiac or respiratory a | arrest, sh | hock, or hear | t | Approximate Interval Between Onset and |
| `xaminer | | Immediate Cause (Final disease or condition resulting in death) | a Hypertensive card | | ar diseas | e | | | | | Death |
| Name of 1 | | | Due to (or as a consequence of | ıf): | | | | | | | |
| | ner | Sequentially list conditions, if any, leading to immediate | Due to (or as a consequence of | of): | | | | | | \dashv | |
| · . | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a consequence of | (f)- | | | | | | | |
| ecuted and transit | | events resulting in death) Last | d | | | | | | | | |
| ian ex | n/Medical | X UNPENDED | ☐ AMENDED #23a,27,p | ren'ME, osk | 52 12/5/0 | 76 TT | | | | | |
| 8760, tificate be ng physic as the bur | /Me | IF FEMALE: 23b. Was decedent pregnant in the | 23c. If yes, outcome of pregr | nancy | | | | 23 | 3d Date of de | elivery | |
| | cian | past 12 months? | Live birth Pregnant at time of dea | 2 Fet | | Ectopic p | pregnancy | | Month | Da | ay Year |
| Box 687 he death certific y the attending property the for use as the | Physicia | 1 Yes 2 No 9 Unkn | own 9 Unknown | | ner (Specify) | | | | | | |
| Records, P.O. Box 6 The law requires that the death cer are has been signed by the attendi age 2 should be detached for use | by Pi | Part II. Other significant condition | contributing to death but not re | esulting in the u | nderlying cause | given in Part | 1.5 | | | | ne cause of death? |
| of Vital Records, P.O ng Physician: The law requires that ther the certificate has been signed by meral director, page 2 should be detaed. | ped | | | | | | | | No 3 | Proba | ably 4 🗸 Unknown |
| cord | Completed | | | | | | | opsy | pric | or to co | opsy findings available impletion of cause of |
| | S. | | | | | | | formed? | | ath? Yes | 2 No |
| Vital ysician: his certifi director, | Be | 25. Was case referred to medical examiner? | Hospital: | | | Othor - | check only one) | | | | beau.d |
| of Vi | 유 | 1 Yes 2 No 27. Manner of Death | T Impatient 2 | ER/Outpatient 28b. Time of In | | | Nursing Home 5 | | lence 6 🗸 | | Scene |
| ~ = ` □ | Certification: | 1 X Natural 5 Pendin | (Month, Day, Year) | Zob, Tille or in | | ury at Work? Yes 2 N | 28d. Describe | a how inj | jury occurrea | 1 | |
| Division tal or Attendi s after death at Director: A | ficat | 2 Accident Investig | igation At he | ome, farm, stree | | | | (Street | and Number | or Rura | al Route Number, City |
| Divorts aff | je [| 3 Suicide 6 Could a determ | HOLDE | | , | | or Town, | State) | and Hambo. | 01 114.4 | Route Number, Ony |
| Divis To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by | ia O | 29a. Certifier 1 Certifying Physics (Check only) | sician: To the best of my knowledg | ge, death occurr | red at the time, o | date and place | e, and due to the car | use(s) ar | nd manner as | s starte | d. |
| Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the | be | one) 2 Medical Exami | iner:On the basis of examination an and manner stated | nd/or investigati | on, in my opinio | n, death occur | rred at the time, date | e and pla | ace, and due | to the | cause(s) |
| | Σ | 29b. Signature and title of certifier | . 11 | | 29c. Licen | | | 29d | Date signed | (Month | n, Day, Year) |
| | | Theother. | M. KT& JR. | m, O | 0.0 | .M.E. | | Nov | vember 19 | €, 200 | 16 |
| | 1 | 30' Name and address of person w Theodore M. King, Jr., N | who completed cause of death (Item). MD. Assistant Medical E. | | 111 Penn S | treet Baltin | more, MD 2120 | 34 | | | |
| St | ate ³ | 31. Date filed (Month, Day, Year) | 32. Segistrar's Signatur | re | | Teet, Daitii | | | | | |
| Regist | | Arass a | 2006 Massac D | Y Bossa | Se se | | | | | | |

| | | 1 | For State Registrar | State of M | aryland / Depa | artment of F | | | giene Reg. N2 0 0 6 | 37871 |
|-------------------|---|----------------|--|--|---|---|-------------------------------------|--|--------------------------|---|
| 5 | * 3 | | 1. Decedent's Name (First, Middle, Las | t) | | | | 2. Date of Dea Month | ath Day Yea | 3. Time of Death |
| | Physici /Medio | | Marvin Frank | Campbell | | | | Novembe | | |
| - | Examir | | 4a. Facility Name (If not institution, give | | | 4b. City, Town, o | | eath | 4c. County of D | |
| | - 34 | | Heartlands Healt | | | Adelph If Under 1 Year | | drs Dotto of Birt | | George's Birthplace (State or Foreign |
| | Funeral Director | | 5. Social Security Number 6. Security Number 12 6. Security Number | 7. AG M∑M 2□F | ge (In yrs. last birthday) 71 Yrs. | Months Days | | lrs. 8. Date of Birt (Month, Day May 17, | 1935 V | Country) |
| (X) | | | Usual Residence of Decedent | | 71 | | | Pay 17 | , 1999 V | 1191114 |
| | yland | | 10a. State 10b. County | | 10c. City, Town or Lo | ocation | | | | 10d, Inside City Limits |
| | a-f si | ctor | MD Prince G | eorge's | Lanha | m | | | | 1 X Yes 2 □ No |
| | or 28 | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of What | Country? |
| | ours after death with the Marylan ral', or Iteme 23a or 28a-f show Examiner - dat be notified as | | 8810 Orbit Lane | | | | 0706 | | USA | |
| | er des | Funerai | 11. Marital Status | 12. Was Decedent Armed Forces | Ever in U.S. 13. | Was Decedent of H II Yes, specify Cubi | lispanic Origin? an, Mexican, Pu | (Specify Yes or No- lerto Rican, etc.) | 14. Race - A Black, W | merican Indian, 'hite, etc. |
| 36 | rs aft | by F | 1 Never Married 2 Married 3 Widowed 4 Wiorced | 1 Tyes 2 1 If Yes, Give Year or Dates: | 1056 50 | 1 ☐ Yes 2 ☐XNo | Specify: | | Specify: | White |
| 21215-0036 | 72 hours after death with the Maryland natural', or Iteme 23a or 28a-f show ural Examiner - unt be notified at | | 15. Decedent's Ed | ucation | 16a. Dece | dent's Usual Occup | pation | | 16b. Kind of Busine | |
| 215 | ⊆ 2 | Completed | (Specify only highest gra- | de completed) College (1-4or | life. | kind of work done DO NOT use retired | during most of (d) | working | | |
| 21 | ie i i | mo; | 8 | | , F | ainter | | | Home Impr | ovement |
| p | be filed ntal Hygi od other event, | Be (| 17. Father's Name (First, Middle, Last) | | | | 18. Mother's ! | Name (First, Middle, | Maiden Sumame) | |
| yla | should be ind Mental marked o | ဥ | Paul Campbell | | | | | e Mae Carr | | 01005 |
| Maryland | ~ 6 | 1 | 19a. Informant's Name/Relationship (7 | | | | | | er, City or Town, Stat | |
| | 1 and 1 Health em 27 | | Fay William Campbe | ell / bro | 20b. Place of Disp | Birdsvil | rre ka. | P.O. BOX | 20c. Location - City | dsonville, MD |
| 10 | Ø O 🖵 🖿 | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ | Removal from State | cemetery, cre | matory or other plac | 1 | | | |
| Baltimore, | permit. Pag Department Important:: any Injury c | | 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Liben | | | tan Crema 2. Name and Addre | | - | Alexandri | |
| Ba | permit. Pag Department Important: I any Injury o | | 21. Signature of Pulletar Service Electric | 1 | 71 B | 5512 NW C1 | | | neral Home e, MD. 2 | 0715 |
| 8 | A * | | 23a. Part1. Enter the disease, or comp | olications that cause | d the death. Do not en | | | - | | Approximate |
| - ja | Dhysisian | | shock, or heart failure. List only of Immediate Cause (Final | | | Hoost Di | 20220 | | | Interval Between Onsel and Death |
| | Physician /Medical | | disease or condition resulting in death) | d | osclerotic s a consequence of): | Heart DIS | sease | | | |
| * | Examiner | | | | | | | | | |
| | êê <u> </u> | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as | s a consequence of): | | | | | |
| | cuted | Examiner | that initiated events | c | | | | | | |
| 0, | be executed sicien and burial-transit | EX | resulting in death) Last | Due to (or as | s a consequence of): | | | | | |
| 8760, | ate hys | dicai | • | d | | | | | | |
| 9 | eath certific attending p for use as i | Physician/Med | IF FEMALE: | 23c. If yes, outcome | e of pregnancy | | | | 224 0-1 | dalli one o |
| Вох | attene for us | ian | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth | 2 Fetal death 3 | Ectopic pregnancy Other (specify) | у | | 23d. Date of Month | Day Year |
| P.O. | at the de by the tached | iysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□ Unknown | | 2 Othor (apoon)) _ | | | | |
| | that ned by deta | | Part II. Other significant conditions of | ontributing to death | but not resulting in the u | ınderlying cause giv | en in Part I. | 23e. Did to | obacco use contribut | e to the cause of death? |
| rds | quires n sign ald be | d by | Colon Cancer, Ca | rdiomyopa | thy, Corona | ry Arter | У | 101 | /es 2□No 3□ | Probably 4 Sonknown |
| CO | law requir as been si 2 should | lete | Disease, Spinal | Stenosis, | Hypertensi | on. | | 24a. Was | an 24b. Were | aulopsy lindings available |
| of Vital Records, | The la | Completed | | | | | | autop perfo | rmed? death | to completion of cause of 1? (es 2 No |
| ita | | 0 | 25. Was case relerred to medical | | | | 26. Place of | Death (Check only o | | |
| ₹ < | S 5 | ToB | examiner? 1 Yes 2 No | Hospital: 1 🔲 Inpat | ient 2 ER/Outpatie | nt 3□ DOA Ot | ner: 4 Nursin | g Home 5 ☐ Resid | dence 6 Other (S | Specify) |
| | | | 27. Manner of Death 1 Natural 5 ☐ Pending | 28a. Date of Inj (Month, D | ury 28b. Time o | 28c. Injui | ry at rk? | 28d. Describe i | now injury occurred | |
| sio | Attendir death. ctor: Al y the fu | catic | 2 Accident investigation | 1 | | M 1 🗆 | Yes 2 □ No | | | |
| Division | l or Attendate after deatl | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 286. Place of II | njury - At home, Jarm, si atc. <i>(Specify)</i> | reet, Jactory, office | | 28f. Location (S City or Tox | | Rural Route Number, |
| | ospital of hours a uneral D | | 000 00000000000000000000000000000000000 | | to form the analysis of the | | | | | |
| | Hospital 24 hours : Funeral stely filled | Medicai | | | t of my knowledge, dea of examination and/or in tated | | | | | |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune | Me | 29b. Signalure and title of certifier | Zira mathrat 3 | | 29c. Licens | se number | | 29d. Date signed (M | onth, Day, Year) |
| | F ≯ F ŏ | | Maria V | falu | ani. | 7- 0 | 5-87 | 76 | 11/13 | 106 |
| | 1/2 | | 30. Name and address of person who | | | , Print) | | | / | |
| K | - Va | + | Doris V. Pablo-B | | | rnum St. | NE #2 | 13 Washir | ngton, DC | 20017 |
| | | ate | 31. Date filed (Month, Day, Year) | 32. Regist | trar's Signature | ٠. | | | | |
| Z | Regist | rar | NOV 1 6 2006 | March | A. Over | | | | | |

| | | | State o | i Maryiai | | irtment of t tificate of | lealth and l Death | - | glene Reg. No. | 06 | 37872 | |
|---------------------|---|--|---|---|-------------------------------------|---|---|--|-------------------------------------|---------------------------------------|---|---|
| ı | Physician | Decedent's Name (First, Mic TAKEETA | | COSBY-S | нтти | | | 2. Dete of De Month | Dey | Year | 3. Time of Death | _ |
| | Medical Examiner | 4e Fecility Neme (If not institut | | |) | | 4b. City, Town, or | NOVEMB Location of Deet | | 2006 of Death | 7:50 PM | _ |
| | 0 | PRINCE GEORG | E'S HOSPIT | AL | | | | VERLY | PRIN | CE GE | ORGE'S | |
| | Funeral Director | 5. Social Security Number 578–22–1717 | 6. Sex 1 ☐ M 2 🖾 F | 7. Age (In yrs 81 | . lest birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | | th ly, <i>Yeer)</i> 20 1925 | 9. Birthpl Count WASH | ace (State or Foreign try) INGTON, DC | 7 |
| | pu & | Usuet Residence of Decedent 10a. Stete 10b. Cour | tv | 10c. C | ity, Town or Loc | cation | | | | 10 | Od. Inside City Limits | _ |
| | Maryl H sho | | E GEORGE'S | | CHEVER | | | | | | 1 X Yes 2 □ No | |
| | or 284 | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen of | Whet Count | ry? | _ |
| | s 23e | 2900 MERCY LA | | | | 20 785 | | | U.S.A | | | |
| 020 | permit. Pages 1 end 2 should be filed within 72 hours eftar death with the Maryland Depertment of Heelth end Mentel Hygiene. Depertment of Heelth end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director | 11. Maritel Status 1 Never Married 2 M. 3 X Widowed 4 Divorce | Armed Fo | 2 (XNo | If | Vas Decedent of H Yes, specify Cub ☐ Yes 2 No | dispenic Origin? (S an, Mexican, Puert Specify: | pecify Yes or No o Rican, etc.) | - 14. Rad Bla Specif | ce - America ck, White, e y: BL | | |
| Maryland 21215-0020 | led within 72 hours e lygiene. Per than "natural", o ft, the Medical Exa. | 15. Deced (Specify only high | ent's Education nest grade completed) | | 16e. Decede (Give k | ent's Usual Occup kind of work done OO NOT use retire | pation during most of wor d) | king | 16b. Kind of B | usiness/Ind | ustry | _ |
| 212 | od with giene giene | Elementary/Secondary (0-12 | College (1 2 y) | -40r5+) CS | | ADMIN. | ASSISTAN | | GOVE | RNMENT | 1 | |
| and | 2 should be filed with end Mentel Hygiene. Is marked other than aumatic event, the I | 17. Father's Neme (First, Middl | e, Last) | | | | 18. Mother's Nan | | | 16) | | _ |
| Ž | 2 should lend Men is marked aumatic | UNKNOWN 19a. tnforment's Name/Relation | nship (Type Print) | | 19h Maiting | n Address /Street | MATTIE and Number or Ru | R. COSB | | State Zin | Code | _ |
| | 1 end 2 : Heelth er em 27 is ither trau | ROBIN ANDREWS | | HTER | | | COURT CAP | | | | • | |
| Baltimore, | Pages 1 ent of He | 20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremetion | 3 DRemovetfrom | | Place of Dispos cemetery, crem | ition (Neme of etory or other plac | ce) | Date | 20c. Location | City or Tov | m, State | |
| Ħ H | permit. Pages Depertment of Important: If It any Injury or o | 4 □ Donation 5 □ Other | (Specify) | | FAMILY I | | | 1/26/06 | Milwaul | kee, Wi | Isconsin | |
| Ba | permit. Depertr Importa any Inji once. | 21. Signature of Funeral Service | OVER ROAD | | ER,MARYI | | . НОМЕ 20785 | | | | | |
| | Physician /Medical Examiner | 23a. Pent1. Enter the diser e, shock, or heart failur. Li Immediate Cause (Final diseese or condition resulting in death) | eAN | TERIOS(| | C CARDIO | VASCULAR | | | | Interval Between Onset and Death | |
| Box 68760, | eath certificete be executed attanding physician and for use as the bunat-transit clan/Medical Examiner | Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that inflieted events resulting in death) Last | c | Due to (c | or as a consequent | ence of): | | 3,43 6 | | | | |
| | at the death cerd by the attandinated for use | Part II. Other significant condit | ions contributing to de | ath but not res | ulting in the und | derlying cause giv | en in Part I. | 23b. Did t | obacco uee co | ntribute to 1 | the cause of death? | - |
| s, P.O | ras that the de iigned by the a be datached i by Physic | | | | | | | 101 | res 2 No | 3 Probe | abty 4 🗆 Unknown | ١ |
| of Vital Records, | sw requir | | | | | | | 24a. Was a perfor | an autopsy med? | avai | e eutopsy findings lable prior to ptetion of cause eeth? | |
| alF | | | | | | | | 1 🗆 Y | es 2 No | 1 🗆 | Yes 20 No | |
| = | # = O | 25. Was cese referred to medic examiner? Tr 1 Yes 2 H No | Hospital: | patient 2X | ER/Outpatient | 3□ DOA Oth | er: 4 Nursing H | th <i>(Check only or</i> ome 5□ Resid | | (Cit.) | | _ |
| | ding Phy h. After this funeral d | 27. Manner of Death 1 ☑Naturel 5 ☐ Pend | 28a. Date o | | 28b. Time of Injury | 28c. Injun Wor | | 28d. Describe h | | | | _ |
| Division | To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: Affert completely filled in by the funeral Medical Certification: | 3 ☐ Suicide 6 ☐ Could | not be 28e. Place | of Injury - At ho g, etc. <i>(Specif</i> | ome, farm, stree | et, factory, office | 22.10 | 28f. Location (S City or Tow | treet and Numb n, Stete) | er or Rural i | Route Number, | _ |
| | Hospi 24 hour Funer stely fill | 29a. Certifier 1 Certify (Check only one) 1 Medica | ng Physician: To the t Examiner: On the ba and mann | sis of examina | wledge, death o tion and/or inve | occurred at the time estigation, in my of | ne, date and place, pinion, death occur | and due to the c red at the time, d | ause(s) and ma late and place, a | nner as sta and due to t | ed. he cause(s) | |
| | To the within 2 To the comple | 29b. Signature and title of certifi | er / | 7 | , | 29c. License | e number | 2 | 29d. Date signed | (Month, D | ay, Year) | - |
| Ì | | Mal | leve | W | | D0185 | 2 | | NOVEMBE | R 14, | 2006 | |
| R | (6) | PAUL A. DEVOR | E M.D. 420 | 3 QUEE | NSBURY | ROAD HYA | TTSVILLE, | MARYLA | ND 207 | 81 | | |
| * | State Registrar | 31. Dete filed (Month, Day, Year | | gistrer's Signa 🗥 | ture de la | , | | | | | | |

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-Iper ME G862 12/08/06dhb

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Dorothy Ellen CROFT NOU 6 /Medical 260 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) West Virginia 6. Sex 7. Age (In vrs. last birthday) Funeral Days 1 □ M 2X F Hours Yrs. 81 Director July 11 1925 220-16-3132 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County r 28a-f show notified at 10d. Inside City Limits show Director 1 X Yes 2 □ No Washington Maryland Hagerstown the 10e, Street and Number 10f. Zin Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be n 11 W. Baltimore Street 21740 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【 No Specify. Specify: 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper 12 Office Supply 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Paul Edward Rider Pearl Viola Bohrer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathie M. Eckel - Daughter 7545 West 311 Louisburg, Kansas 66053 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 11/13/06 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Maryland 21740 ista Tred Lub 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onget and Death Immediate Cause (Final disease or condition resulting in death) **Physician** dou /Medical Due to (or as a consequence of) Examiner TION APPROTED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the attending p ass IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Month Day Year ed by the a detached f 5 Other (specify) 9 Unknown signed by t Part I O er significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>Ş</u> cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1□ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Ves 2€ Ne ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 No 11/10/2006 **Unknown**^M Subject fell 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, StateHagerstown, MD 11 W. Baltimore St., Apt. 222 determined 4 ☐ Homicide Home Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 2 ☐ Medical Examiner; 29b. Signature and title of certifier 29c. License number 3623 11 10/s

SH-3

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) NOV 1 4 2006

Edure

32. Registrar's Signature

111

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Sperke

mil

ORIGINAL

1111

modrael

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** November 10 2006 0340 Melvin Carter /Medical 4c. County of Death 4a. Fecifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10XM 2□ F Yrs. Director March 31,1932 217-28-5847 Maryland Usual Residence of Decedent the Maryland 10d, fnside City Limits 10a. State West 10b. County 10c. City, Town or Location i Hygiane. other than "natural", or Iteme 23a or 28a-f ehov vent, Itra Medical Examinar Invat Le notified at 1 ☐ Yes 2 No Director Virginia Berkeley Falling Waters 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 25419 USA 76 House Lane death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 195 If Yes, Give Year or Dates: 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married 1952 Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 1954 Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Law Enforcement permit. Peges 1 end 2 should be filed v Depertment of Heelth and Mental Hygian Important: if Item 27 is marked other It eny injury or other traumatic event, ITE 900. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Brinham Harry Samuel Carter, Sr. Anna Isabelle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>Wilma M. Carter - Wife</u> 76 House Lane Falling Waters, West Virginia 25419 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Greenlawn Mem. Park Nov.14,2006 Williamsport, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Scotto Lio non Osborne Funerally Home, P.A. 425 S. Conococheague St. Williamsport. Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Examiner Cancer ancrea Sequentially list conditions, if any, leading to infunediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Pe 3 Probably 4 □Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2 No 2 No 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Yes 2 No 3 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred fnjury 1 Natural 5 Pending 1 Yes 2 No investigation within 24 hours efter death To the Funerel Director: A completely filled in by the fi 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide 29a. Certifier I Certifying Physician. To the best of my knowledge, death occurred at the time, date and plane, and due to the causa(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5060396 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 0701 31. Date filed (Month, Day, Year) 3 2006 MUN 5 HET 32. Registrar's Signature State Registrar

| | | | 1_ For Ame | Plea: amer nd item#1 | se Tyr 2. nerb | pe or F em 18 tate of | Print per Mar | in Black c fh yland 2/6/04 | ack in 2862 Dep | delible artmer | 4-06 nt of F | En VE lealt | sure A h and N | II Cop Iental | ies A Hygi | Are Le | egible. | 3 | 7875 |
|----------------|--|-----------------|--|--------------------------------------|--------------------------|-------------------------------------|---------------------|-------------------------------------|-------------------------------------|----------------------------|---------------------|-------------------|---------------------|------------------------|--------------------|------------|--------------------|-------------|---|
| | | | - State Talk | nd really r | 2,pc11 | 11, 000 | | | Ce | rtificat | e of | Dea | th | | Ke | g. No. | | , 0 | 1010 |
| | Physici /Medic | | 1. Decedent's Nan | ne <i>(First, Middle</i> e Dennis | | kerv | | | | | | | | 2. Date Mont Oct | | Day 2006 | Year | r | Time of Death |
| 5 | Examir | | 4a. Facility Name | | | | iber) | | | 4b. City, | Town, or | r Locati | on of Death | | | 7 | unty of De | | 1 |
| | | | 5308 Wa | apakonet | ta RD | | | | | Bet | hesd | a | | | | Mon | tgome | ery | |
| | Funeral | | 5. Social Security | Number | 6. Sex | | 7. Age (| In yrs. las | t birthday) | If Unde Months | r 1 Year Days | If Und | der 24 Hrs. | 8. Date (Moni | of Birth | Year) | 9. B | irthplace (| (State or Foreign |
| | Director | | 072-16- | | M LALI | 2 🗆 F | 8 | 5 | Yrs. | | | | | | 10, | | N | ew yo | ork |
| | pur . | | Usual Residence | of Decedent 10b. County | | | 1 | Oc. City. | Town or Lo | ocation | | | | | | | | 10d. In | side City Limits |
| | sho | 5 | MD | Montgo | 7me 1537 | | | _ | iesda | | | | | | | | | | ☑Yes 2 No |
| | Ne N | Director | 10e, Street and No | | Jile L y | | | DCCI | - Julia | 10f 7ir | o Code | | | | 10 | o Citizar | of What (| | |
| | hours after deeth with the Maryland tural', or Itema 23e or 28e-f show al Examinar must be notified at | 급 | | | | | | | | | | _ | | | | | _ | | |
| | 99th | by Funeral | 5308 Waj | pakoneta | | Was Deced | dent Ev | er in II S | 13 | | 2081 | | Origin? (Sp | ecty Ves | | - | ed St Race - An | | dian |
| | item item | Ę. | 11. Marital Status | rried 355 Marri | | Armed Ford | ces? | | 10. | If Yes, spe | cify Cuba | n, Mex | ican, Puerto | Rican, et | c.) | ' '' | Black, Wh | | J. W |
| 36 | irs af | by F | | 4 □ Divorced | | If Yes, Give Year or Da | B | | 947 | 1 ☐ Yes | 21/2 No | Spec | city: | | | Sp | ecity: W | hite | |
| 21215-0036 | d within 72 hours after deeth with the Marylan liene. r than "natural", or itema 23e or 28a-f show the Madical Examinat must be notified at | pe | | 15. Decedent | 's Education | on | | | 16a. Dece | dent's Usu | al Occup | ation | | | 1 | 6b. Kind | of Busines | s/industry | , |
| 215 | within 7. ene. than "n | Completed | (Spe | cify only highes | | ompleted) College (1- | 40r 5+) | | | DO NOT u | | | nost of work | ang | | | | | |
| 2 | d with | E O | Liomontaryrood | , on early (0 12) | | 4 | | | Info | rmati | lon S | Spec | ialis | t | | US I | ent (| Of St | ate |
| b | be filed stat Hygie of other avent, | Bec | 17. Father's Name | (First, Middle, | Last) | | | | | | | 18. M | other's Nam | e (First, M | liddle, M | | | | |
| <u>a</u> | Jental I | 10 | Dennis | Joseph | Cork | cery | | | | | | | nna 🔻 | | | | | | |
| Maryland | d 2 should th and Men ?7 ie marke traumatic | | 19a. Informant's I | | | | | | | | | | m <i>ber</i> or Rui | | | - | | Zip Code | e) |
| | of Health itam 27 i | | Mary L. | Corker | y/Wif | е | | | 5308 | Wapa | akone | eta | Rd, B | ethes | da,M | 10 20 | 816 | | |
| Baltimore, | of Healt fitam 2 rother | | 20a. Method of Di | sposition Cremation | 2 □ Bam | oval from S | tata | 20b. Plac | ce of Dispo ne <i>tery, cr</i> e | osition (Na matory or o | me of other plac | :ө) | | Date | 2 | 0c. Locat | ion - City o | or Town, S | State |
| Ĕ | permit. Pages Department of Pinportent: if its any injury or of once. | | | 5 Other (S | | 04211101113 | nate | Gate | e of | Heave | en Ce | em | 11-4- | -06 | | Silv | er S | oring | , MD |
| at | Departr Maport any inj | | 21. Signature of F | unecal Service | Licersee | | | | 2: | 2. Name a | nd Addres | ss of Fa | acilityJos | eph G | aw1e | er's | Sons | , INC | |
| m | 897 29 | | W. | WY 1 | Meleye | uf | | | | 5130 | Wisc | ons | in Av | e,N.W | . Wa | shin | gton | DC 2 | 0016 |
| 45 | Para and a second | | Immediate Cause | art failúre. List (Final | only one c | ions that ca ayse on ea Aorti | ich line. | | | ter the mod | de of dyin | g, such | as cardiac | or respirat | ory arres | st, | | Inter | roximate val Between et and Death |
| 1 | Physician /Medical | | disease or condit resulting in death | | a | Due to (o | | | | | | | | | | | | | |
| 2 | Examiner | | | | | 200 10 (0 | | , sinooquo. | | | | | | | | | | | |
| | | ē | Sequentially list of any, leading to | onditions, immediate | b. – | Due to (o | or as a | onseque | nce of): | | | | | | | | | | |
| | be executed siclen end burial-transit | Examiner | cause. Enter Und Cause (Disease of that initiated even | or injury | | | | | | | | | | | | | | | |
| ó | be execut iclen end burial-trar | Exa | resulting in death) | Last | | Due to (o | or as a c | conseque | nce of): | | | | | | | | | 1 | |
| 1200 | cate be ohysicil the bu | G | | | | | | | | | | | | | | | | | |
| 687 | deeth certificate e attending phys d for use as the | Aed | IF FEMALE: | | | | | | | | | | | | | | | | |
| Вох | eeth certific attending p | an/h | 23b. Was decede | | | If yes, outcome 1 ☐ Live bir | | | | ∃Ectopic p | regnancy | | | | | 23d | . Date of de | , | W |
| | | sici | in the past 1: | □No | | 4☐Pregna | | ne of deat | th 5[| Other (sp | oecify) | | | | | | Month | Day | Year |
| P.0 | at the de t by the steched | Physician/Medic | 9 Unknow | | | | | | | | | | | | 5 11.1.1 | | | | |
| | requires thet the leen signed by th hould be deteche | Ď | Part II. Other sign | ry Artei | | | | not resulti | ng in the u | inderlying | ause givi | en in Pa | art i. | 230. | | | | | ise of death? |
| ord | w requir been si should | Completed | + | | | | | | | | | | | | 1 Yes | 2 12 N | 0 3∐F | robably | 4 Unknown |
| Vital Records, | aw Is b | pie | Conges | tive Hea | art F | ailur | е | | | | | | | 24a. | Was an autopsy | | prior to | compteti | ndings available on of cause of |
| <u> </u> | Th ete pag | ် ပ | | | | | | | | | | | | 10 | perform res 2 [| | death? 1 □ Ye | s 2 l | No |
| ita | Phyalcian: Th this certificete ral director, pag | Be | 25. Was case refe examiner? | erred to medical | | | | | | | | | ace of Deat | h (Check | only one |) | | | |
| 6 | G S | ပ္ | 1 ☐ Yes 2 ☐ | | Hosp | ı 🗀 in | | - | VOutpatie | | | 4 🗀 | Nursing Ho | | | | | ecify) | |
| Ē | | ii O | 27. Manner of Dea 1 ∰Natural | 5 Pending | g | 8a. Date of (Month | f Injury , Day Y | ear) 21 | Bb. Time o Injury | | 28c. Injun Work | | | 28d. Desc | ribe how | v injury o | curred | | |
| Sic | Attending r death. ector: After by the fune | cat | 2 ☐ Accident 3 ☐ Suicide | investig 6 ☐ Could r | of he | 0.01 | -4 l-1 | 41 5 | - 4 | M | | Yes 2 | □No | 206 1 222 | inn /Ct | | | 2/ 0 | - M b |
| Division | or Attan efter deat Director: in by the | Certification; | 4 Homicide | datama | | 28e. Place o building | g, etc. (| (Specify) | e, tarm, sti | reet, factor | у, опісе | | | | or Town, | | umber or r | Hurai Hou | te Number, |
| _ | To the Hospital or Attani within 24 hours efter deatl To the Funeral Director: completely filled in by the | Ö | 29a. Certifier | 1 Certifyin | g Physicia | an: To the b | best of | my knowle | edge, deat | h occurred | at the tin | ne, date | and place. | and due to | the cau | ıse(s) anı | d manner a | as stated | |
| | • Hos | edicai | (Check only one) | 2 Medical I | Examiner: | On the bas | sis of ex | camination | n and/or in | vestigation | , in my o | pinion, | death occur | red at the | time, dat | e and pla | ice, and du | e to the c | ause(s) |
| | To the I within 2 To the I complet | Me | 29b. Signature an | dutle of certifier | 11 | AC | / | 2 | ,9 | 29 | c. License | e numb | er | | 290 | d. Date si | gned (Mor | nth, Day, 1 | Year) |
| • | 10 | | • (| Ul. C | 11 | lu | | 17/ | | | D071 | 47 | | | 1 | 1-01 | -2006 | | |
| | Ψ | | 30. Name and add | dress of person | who compl | leted cayse | of dea | th (Item 2 | 3a) (Type, | | | | | | | | | | |
| _ | | | Allen | Nimetz, | M.D. | 5530 | Wis | cons | in Ax | ze Cl | hevv | _Cha | se,MD | | | | | | |
| | Sta | | 31. Date filed (Me | oth Day, Year) | 2006 | 32 Re | gistrar's | Signatur | θ | AND B | - | | | | | | | | |
| | Registr | ar | 1/4 | 00 | ۷,000 | F8.9 | 9, 12 1 | J | 10/0/50 | | | | | | | | | | |

06-08669 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Ferdinand Cuevas 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Year 1115 hrs **Medical Examiner** November 14, 2006 Ferdinand Cuevas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 20708 Spinning Wheel Place Germantown Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or **Funeral** oreian Country) Rico Days Director 582-15-8576 April 29, 1958 1 X M 48 2 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 X No 28a-f show Maryland items 23a or 28a-f shoust be notified at once. Montgomery Germantown Directo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20225 Shipley Terrace #201 20874 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 1 X Yes 2 No "natural", or 4 Divorced If Yes, Give Year Unknown 3 Widowed 1X Yes 2 No specify: Puerto Rican Specify: tem 27 is marked other than "natural", traumatic event, the Medical Examiner White ģ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) more, MD 21215-0036
Pages I and 2 should be filed within 72 I Non Profit Org. Social Worker 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) If item 27 is marked Ferdinand Cuevas, Sr. Cecilia Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20225 Shipley Terrace #201, Germantown, MD 20874 Cynthia A. Cuevas / Wife 20a, Method of Disposition

1 Burial 2 X Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Nov. 20. Baltimore, crematory or other place)
Riverdale Park
Crematory or other Department o Important: | 2006 Riverdale, Maryland Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of ineral Seption Thibadeau Mortuary Service, 933 Gist Avenue, LL, Silver P.A. Spring, M00956 MD 20910 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Diphenhydramine intoxication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED attending physician or use as the burial AMENDED #23a,27,28a-f, perME, g862, 12/5/06 TT The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Linknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of death? performed? 1 🗸 Yes ✓ Yes 2 25. Was case referred to medical 26 Place of Death (Check only one) To the Hospital or Attending Physician: of Vital Be Hospital: 1 Other₄ examiner? Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this ٩ 1 🗸 Yes No 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After Certification: Division Natural 1 Yes 2 No Director: Fnd 11/14/2006 Fnd 11:15 am unknown 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide or Town, State) 20708 Spining Wheel Pl. determined (Specify) house To the Funeral Homicide Germantown. MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 3 O.C.M.E. November 15, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 31. Date filed (Month, Day, Yes 32 Registrar's Signature State 2006 Godin Registrar

| | | | State of Maryland / Departmen | nt of Health and Nate of Death | - | |
|----------------------------|--|-------------------------------------|--|--|--|---|
| x 50 | Physic /Med Exami | cal | SHIRLEY ANN COLEMAN-HALL | Town, or Location of Death | NOVEMBER | Year 3. Time of Death 11, 2006 11:15P M |
| | Funeral Director | | WASHINGTON ADVENTIST HOSPITAL 5. Social Security Number 6. Sex 1 | TAKOMA PARK | 8. Date of Birth (Month, Day, Year | MONTGOMERY 9. Birthplace (State or Foreign |
| nore, Maryland 21215-0036 | Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 ie marked other then "natural", or Iteme 23a or 28a-f ehow ity or other traumatic event, the Madical Examiner must be notified at | To Be Completed by Funeral Director | 3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes | 20020 dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto MTN o Specify: al Occupation and of work of work of work one during most of work of w | al Route Number, City | 10d. Inside City Limits XXYes 2 □ No itizen of What Country? JNITED STATES 14. Race - American Indian, Black, White, etc. Specify: BLACK Kind of Business/Industry UNIVERSITY HOSPITAL in Sumame) |
| Baltimore, | permit. Page Department of Important: if eny injury or once. | | 4 Donation 5 Other (Specify) FORT LINCOLN | HOME OF M | BRENTWOOD, MD ARYLAND, INC. D, MD 20746 | |
| | Tificate be executed Naminer as the buriat-transit | edical Examiner | Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, I any, I along to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): | rodz | or respiratory arrest, | Approximate Interval Between Onset and Death |
| P.O. Box | death cei e attendir id for use | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic prices to the past 12 months? 4 □ Pregnant at time of death 5 □ Other (spin of the past 12 months) | | | 23d. Date of delivery Month Day Year |
| | law requires that the as been signed by th 2 should be detache | Ď | Part II. Other significant conditions contributing to death but not resulting in the underlying ca | tusa given o Part I. | 23e. Did tobacco o | use contribute to the cause of death? |
| ital Re | The ste ha | Be Completed | 25. Was case referred to medical | 26. Place of Death | 24a. Was an autopsy performed? 1 Yes 2 No | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |
| Division of Vital Records, | if or Attending Physician: after death. Director: After this certification by the funeral director. | Certification: To | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DO | A Other: 4 Nursing Hon Bc. Injury at Work? 1 Yes 2 No | πe 5 ☐ Residence 28d. Describe how injur | ry occurred od Number or Rural Route Number. |
| | To the Hospital or Attending Ph within 24 hours alter death. To the Funeral Director: Alter th completely filled in by the funeral | ledical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred a course of examination and/or investigation, and manner stated. | at the time, date and place, a in my opinion, death occurre | and due to the cause(s) ad at the time, date and | |
| R | (3) | | | ~ | | 1-12 -06 MD 20715 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 1 5 2006 32. Registrar's Signature | | الع المال المال | |

State of Maryland / Department of Health and Mental Hygienes 37878 1 - For State Registrate Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 00°16 M LAWRENCE COPELAND 06 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE CLINTON MARYLAND HOSPITAL SOUTHERN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APR. 29, 1 5. Social Security Number 6. Sex XXM 2□ F 9. Birthplace (State or Foreign **Funeral** Days Hours Yrs. Director 78 579 32 2553 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits J. Hygiene. other then "natural", or Itama 23a or 28a-1 show vent, the Medical Exeminer must be notified at XIX Yes 2 □ No Director PRINCE GEORGES FORESTVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3107 FOREST RUN DRIVE 20747 UNITED STATES by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married XXIYes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: BLACK 3 ☐ Widowed XX Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11TH SALESPERSON SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fit tment of Health and Mental H tant: If Itam 27 is marked ott jury or other traumettc even OSCAR D. COPELAND VIRGIE ALTERMILBURY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3107 FOREST RUN DRIVE FORESTVILLE, MD 20747 MARIE E. DOOMS / COMPANION 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial XX Cremation 3 Removal from State Department of important: If sny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 11/16/06 ALEXANDRIA, VA 21. Signatore of Funeral Service Licenses 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypoxic **Physician** encephalopathi 5 day /Medical Due to (or as a consequence of): Examiner Prolonged arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and ned for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed is day fallow Renal Due to (or as a consequence of): Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HO CAD 3 ☐ Probably 4 ☑ Unknown cate has been significated page 2 should b 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 22 No 1 Inpatient 1 ☐ Yes Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending after death.

Dirsctor: Aft
d in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funersi C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) V. Kaman MD D0063183 14/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1503 VIJAY SHRI CLINTON, MD KANNAN SURRATTS ROAP 31. Date filed 32. Registrar's Signature State Registrar

| | | | 1- For State Registrar Amended #41 | State of Ma | | _ | | | lealth a Death | | - 10- | jiene | 006 | 37879 | |
|-------------------|---|----------------|--|--|-------------|------------------------------|------------------------|--------------------|---------------------------------------|--------------------------|---|-------------|------------------------|--|----------|
| | Physici | an | Decedent's Name (First, Middle, Las | t) | , | <u> </u> | | | | | 2. Date of Dea Month | | Year | 3. Time of Death | _ |
| | /Medic | cal | 4a. Facility Name (If not institution, give | Casta | nho | | 4b. City | Town or | Location o | of Death | _// | 12 | 2000 ounty of Dea | 0 11:27 AM | _ |
| | Examir | ier | Howard County Fa | · · | | | | | riend | | 119100 | | ن سويد ف | | |
| | Funeral Director | | 5. Social Security Number 6. So | 9x 7. Ag ▼ M 2 F | | last birthday) Yrs. | If Under Months | 1 Year Days | If Under a | Min. | 8. Date of Birth (Month, Day FEB 22 | Year) | 9. Bi | rthplace (State or Foreign country) |) |
| | D D | | Usual Residence of Decedent | | 68 | | | | | | FED. ZZ | , 193 | o Nev | v Jersey | |
| | Aarylar I ehow | ō | 10a. State 10b. County Maryland Freder | ick | 10c. Cit | y, Town or Lo Freder | | | | | | | | 10d. Inside City Limits 1 X Yes 2 ☐ No | |
| | r 28a- | Director | 10e. Street and Number | | | | 10f. Zip | Code | | | 1 | 0g. Citize | n of What C | | _ |
| | ath wit | raiD | 400 Pearl S | t. | | | 21 | 1701 | | | | Unit | ed S | tates | |
| 920 | be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel" or iteme 23e or 28e-1 ehow event, the Medical Exartical must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Armed Forces? 1 [X] Yes 2 [] If Yes, Give Year or Dates: | | i | Vas Deced Yes, spec | offy Cuba | spanic Orig n, Mexican Specify: | gin? (Spec , Puerto F | cify Yes or No- Rican, etc.) | | Black, Whi | encan Indian, ite, etc. White | |
| 15-0 | "natur | leted | 15. Decedent's Ed (Specify only highest grad | ucation de co <i>mpleted)</i> | | 16a. Deced | kind of woi | rk done d | turina most | of workin | g | 16b. Kind | of Business | s/Industry | _ |
| 21215-0036 | s withir iene. r then | Completed by | Elementary/Secondary (0-12) | College (1-4or 5 | i+) | | oo NOT us lail | Cle1 | | | | | Bank | | |
| Maryland 2 | 2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, the Mi | To Be C | 17. Father's Name (First, Middle, Last) Antonio | Castanl | no | | | | | rs Name aura | (First, Middle, I | | ımame) | | |
| Mar | s t and 2 should f Health and Men Item 27 is marke other treumatic | 1 8 | 19a. Informant's Name/Relationship (7) Linda Castanho / | | | | _ | | | | Route Number | . , | | Zip Code) 21701 | |
| | s t and if Health Item 27 other tr | | 20a. Method of Disposition | | 20b. P | Place of Disposemetery, cren | sition (Nan | ne of | T | | | | | Town, State | _ |
| Baltimore, | Pages ment of I ant: If It | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify |) | | ederick | Cre | emato | ory | 11/19 | 7/00 | | | Maryland | |
| Ball | permit. Pages 1 and 2: Depertment of Health at Important: If Item 27 is eny injury or other treusing. | | 21. Signature of Funeral Service Licen | Stauffe | 4 | 16 | 21 Or | ossı | ımtowi | n Pik | uffer F e / Fre | ederi | | | |
| П | | | 23a. Part 1. Enter the disease or companion of the compan | lications that caused one cause or each lin | the deatl | h. Do not ente | er the mode | e of dying | g, such as o | - 1 | 0 1 | | | Approximate Intervat Between Onset and Death | |
| | Physician /Medical | | disease or condition resulting in death) | a. Due to (or as | a consequ | uence of): | 7600 | rd10 | 1 . | my | actio. | <u>`</u> | | | |
| | Examiner | _ | Sequentially list conditions, | b C 0 | run | ary | 01 | -te | 7 | dis | eale | | | | |
| | rted f | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as | a consequ | uence off: | 0/4- | | / | | | | | | |
| oʻ | cate be executed physicien and the burial-transit | | that initiated events resulting in death) Last | Due to (or as | consequ | uence of): | | | | | | | | | - |
| 8760, | cate be physici the bu | dicai | • | d | 7/2 | w lig | ، رط ه | 121 | 64 | | | | | | _ |
| . Box 6 | death certificate be executed to estending physicien and ed for use as the burral-transit | Physician/Me | in the past 12 months? | 23c. If yes, outcome 1 Live birth 4 Pregnant at | 2 🗌 Fetai | death 3 | Ectopic pro | | | | | 230 | d. Date of de Month | livery Day Year | |
| P.0 | thet the de ed by the detached | | 9 ☐ Unknown Part II. Other significant conditions co | | ut not resu | ulting in the un | derlying c | anse dive | n in Part I | | 23e Did tob | Dacco use | contobute t | o the cause of death? | _ |
| of Vital Records, | es De De | ed by | | | | | | 2030 9.10 | | _ | | s 2 🗆 t | | robably 4 Dunknown | |
| 000 | law requir as been s 2 should | Completed | | | | | | | | | 24a. Was ar | | 24b. Were a | utopsy findings available | - |
| E B | | | | | | | | | | | perform | | death? | completion of cause of 2 □ No | |
| Vit. | Physiclan: this certific ral director, | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 No | Hospital: 1 ☐ Inpatie | ot 2 | ER/Outpatient | 2□ 00 | A Othe | | | Check only on | - | to 10 | . Foirement | . 4 |
| on of | ding Phy J. After this funeral c | | 27. Manner of Death 1 ∯Natural 5 ☐ Pending | 28a. Date of Injur (Month, Day | | 28b. Time of Injury | 20 | Bc. Injury Work | at ? | 28 | e 5 Heside 3d. Describe ho | | | city) Fairgroun | I |
| Division | tal or Attending Pt s after death. al Director: After th ed in by the funera | Certification; | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Ptace of Injubulding, etc. | iry - At ho | ome, farm, stre | M et, factory | | ′es 2 □ N | | Bf. Location (Sti City or Town | | Vumber or R | ural Route Number, | - |
| | To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completely filled in by the | | 29a. Certifier 1 Certifying Phy | sician: To the best of | of my kno | wledge, death | occurred a | at the tim | e, date and | l place, ar | nd due to the ca | iuse(s) an | nd manner a | s stated. | - |
| | To the He within 24 To the Fu | Medical | one) | iner: On the basis of and manner sta | examinat | tion and/or inv | estigation, | in my op | inion, death | h occurred | d at the time, da | ate and pla | ace, and due | e to the cause(s) | |
| | T Wit | | 29b. Signature and title of certifier | King y | n. | 0. | / | License | 200 | 026 | , a | | / | h, Day, Year) | |
| 1 | 5 | | 30. Name and address of person who c | ompleted cause of de // 6 www. 32. Registre 6 2006 | ath (Item | 23a) (Type, I | Print) | | 380 | 11 | | | 11/ | / 0 0 | \dashv |
| | | | Mark king 31. Date filed (Month, Day, Year) | 176 www. | d Co | in to | Gen | ieral | Hosy | ni tal | , Ced | ortai | ne, C | vlumbia Mx |) |
| | Sta Registr | | NOV 1 | 6 2006 ▶ | College. | J | Soci | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes of According to the All Copies Are Legible.

| | | | 1 - State Registrar | State of Maryla | | | of Death | | ene2 0 0 8 | 37880 |
|-------------------|--|---------------|---|--|--------------------------------------|--|---|--|--|--|
| | Physici | an | Decedent's Name (First, Middle, Last) | _ | | | | 2. Date of Death Month | _ | 3. Time of Death |
| | /Medic | al | Hal Eugene Clagett, 4a. Facility Name (If not institution, give stre | | | 4h Cih. To | un or Location of Doo | November | 9,2006 Yee | 9:24 p M |
| | Examin | er | Southern Maryland H | | | Clint | wn, or Location of Dea | UI | Prince G | |
| Н | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs | s. last birthday) | If Under 1. | fear II Under 24 Hr | | | irthplace (State or Foreign Country) |
| | Director | | 370-32-3201 | ^{2□} F 66 | Yrs. | Months [| ays Hours Mir | March 3 | 1,1940 W | ashington DC |
| | yland | | Usuel Residence of Decedent 10a. State 10b. County | 10c. C | ity, Town or Lo | cation | | | | 10d. Inside City Limits |
| | Ba-f | Director | Maryland Charles | В | ryans R | load | | | | 1 ☐ Yes 2 X No |
| | 를 6 6 2 8 2 | Dire | 10e. Street and Number | | | 10f. Zip Co | | 10 | g. Citizen ol Whal | Country? |
| | 23a | rai | 7317 Judi Drive | | | | 616 | | U.S.A. | |
| 336 | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mentel Hygiene. Item 27 ie marked other then "natural", or iteme 23a or 28a-f show other treumatic event, the Medical Experient mark the rotified at | by Funerai | 11. Marital Status t □ Never Married 2 Married 3 □ Widowed 4 □ Divorced | Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: | | Was Deceden fYes, specify I□Yes 212 | I of Hispanic Origin? (Cuban, Mexican, Pue No <i>Specify</i> : | Specify Yes or No- rto Rican, etc.) | Specify: Wh | |
| Š | 2 hou | ted | 15. Decedent's Educat | ion | 16a. Deced | lent's Usual C | occupation | 1 | 6b. Kind of Busines | |
| 21215-0036 | within 7 ane. then "n | Completed | (Specify only highest grade of Elementary/Secondary (0-12) | College (1-4or 5+) | | | done during most of we etired) | | Flootria | Power Plant |
| | Hygie Hygie other | | 17. Father's Name (First, Middle, Last) | | Meter | Reade | | me (First, Middle, M | | rower rianc |
| Maryland | 2 should be fited within and Mentel Hygiene. Is marked other then eumatic event, the Me | To Be | Jack Clagett | | | | Kather | rine B. Da | venport | |
| lary | 2 should and Men ie marke eumatic | | 19a. Informant's Name/Relationship (Type, | Print) | 19b. Mailin | g Address (S | treet and Number or F | lural Route Number, | City or Town, State | , Zip Code) |
| - | and ealth m 27 | | Margaret A. Clagett | | | | rive, Brya | | | |
| Ö | it of H | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem | | Place of Dispo cemetery, cren | ratory or other | r n/a ce l | | 0c. Location - City | or Town, State |
| Baltimore, | permit. Pages 1 and 2 Depertment of Health a Importent: if Item 27 is eny Injury or other tre | | 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensel | S | t. Char | les Ce | metery 13 | I. | ndian Hea | d, Maryland |
| Ba | Depermine Depe | | n 1/1 | ₩ 9 M006 | - W | lilliam | s Funeral | Home, P.A | Head Md | 20640 |
| | | | 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one | cause on each line | | | | | | Interval Herween |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | | 9) | Neu | moma | | | Onset and Death |
| | /Medical Examiner | | | Due to (or as a conse | equence of): | 1 7 | Ox | 1 | • | Conser and Death Conser and Death Conser and Death Conser and Death Conser and Death |
| | | Jer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a conse | equence of): | -/-// | 1 x x x | uer . | 7 | Con Know |
| | acuted nd transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| 60, | icate be executed physiclen and s the burial-transit | al Ex | resulting in death) Last | Due to (or as a conse | quence ol): | | | | | |
| 68760, | tificate ng physi as the | edical | d | | | | | | | |
| Box (| eath certif attending for use a | n/Me | IF FEMALE: 23b. Was decedent pregnant 23c. | Il yes, outcome ol pregr 1 ☐ Live birth 2 ☐ Fet | | lc | | | 23d. Date of d | elivery |
| | The law requires thet the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the bural-transit | Physician/M | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4☐Pregnant at time of 9☐Unknown | | Ectopic pregi Other (speci | | | Month | Day Year |
| , P.O | res thet the igned by be detact | | Part II. Other significant conditions contril | outing to death but not re | sulting in the ur | nderlying caus | se given in Part I. | 23e. Did toba | acco use contribute | to the cause of death? |
| of Vital Records, | w requires been sign should be | ed by | Mand from | lun 1 | typo | 18~ | SION | 1 ☐ Yes | s 2 No 3 | Probably 4 Hinknown |
| eco | e law requ hes been je 2 shoul | Completed | avenia | | | | | 24a. Was an autopsy | 24b Were | autopsy findings available completion of cause of |
| <u>~</u> | | Con | gostrity | | | | | perform | ed? death' | |
| Vita | Physicien: Th this certificete rat director, pag | Be | 25. Was case eferred to medical examine? | pital: | | | Other | ath (Check only one | | |
| o | Phys this at di | . To | 1 Yes 2 No | 1 Inpatient 2L | ER/Outpatien 28b. Time of | | | Home 5 ☐ Resider | | pecify) |
| on | th. : After is funera | tion | 1 Natural 5 Pending 2 Accident Investigation | 28a. Date of Injury (Month, Day Year) | Injury | м | Injury at Work? 1 ☐ Yes 2 ☐ No | | · ···································· | |
| Division | er dea | Certification | 2 Suside 6 Could not be | 28e. Place of Injury - Al I building, etc. (Spec | home, larm, stre | eet, factory, o | ffice | 281. Location (Stre City or Town, | | Rural Route Number, |
| Ö | ital or | | | | | | | | | |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer | Medicai | 29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examines | an: To the best of my kr On the basis of examinand manner stated. | nowledge, death nation and/or inv | occurred at treating at the street of the st | he time, date and place my opinion, death occ | e, and due to the car urred at the time, da | use(s) and manner te and place, and d | as stated. ue to the cause(s) |
| | To th Withir Comp | Me | 29b. Signature and little of certifier | 11 | | 29c. L | icense number | 29 | d. Date signed (Mo | nth, Day, Year) |
| | | | 1 traf | roof | | 55 | 924 | N | ove and | 30/06 |
| 5 | P 1671 | | 30. Name and address of person who comp | eleted cause of death (Ite | em 23a) (Type, | Print) | oeing m | 0 2090 | 2 | • |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 1 4 | 32. Registrar's Sign | nature | Sperk | , | | | |

| | | | For State - State Registrar | of Maryland / Department of Health and M Certificate of Death | Mental Hygiene |
|-------------------|--|------------------|---|---|---|
| I | Physicia | an | 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) | aaAD | 2. Date of Death Month Day Year N M M M M M M M M M M M M M M M M M M M |
| | /Medic Examin | | 4a. Facility Name (If not institution, give street and n | (umber) 4b. City, Town, or Location of Death | 4c. County of Death |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) O 12-143 9. Birthplace (State or Foreign Country) |
| | Director | | Usual Residence of Decedent | ,5 Yrs. | |
| | Aaryland f show | ō | 10a. State 10b. County | 10c. City, Town or Location SALISBURY | 10d. Inside City Limits 1 Ves 2 □ No |
| | or 28a- | Funeral Director | 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
| | death v ems 23a | neral | 11. Marital Status 12. Was De Armed | cedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe forces? 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto | ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. |
| 920 | within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examinat nust to indiffed at | þ | 1 Never Married 2 Married 1 XXes | 2 No. | Specify: WHITE |
| 21215-0036 | n "natur | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Sepondary (0-12) College | IIfe. DO NOT use retired) | ing 16b. Kind of Business/Industry |
| | filed with Hygiene. Ather than | | 17, Father's Name (First, Middle, Last) | 1 ELECTRICAL LECHINA | 11770 POWER e (First, Middle, Maiden Sumame) |
| Maryland | should be and Mental I smarked o | To Be | WILLIAM JAMES CA | arah Sarah | 1 CARTER |
| | 27 Is | | 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rura | USBURY MOD BROY |
| nore, | Pages 1 an nent of Heal out: If item 2 iry or other | | 20a. Method of Disposition 1 | comptent crematoni or other place) | Date 20c. Location - City or Town, State |
| Baltimore, | permit. Pages Department of Importent: If i eny injury or once. | | 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility MESSICK FUNERA | No Pari Ci |
| | 20 ≥ 6 0 | | 23a. Part1. Enter the alsease, of complications that shock, or hear failure. List only one cause or | caused the death. Do not enter the mode of dying, such as cardiac of each line. | or respiratory arrest, Approximate Interval Between |
| | Pnysician /Medical | 1 8 | Immediate Cause (Final disease or condition resulting in death) | Congrestive Heart Failure | Onset and Death |
| ı | Examiner | Ļ | | o (or as a consequence of): | - DE ZUYNA |
| | nd nd transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events c | | |
| ,092 | icate be executed physician and s the burial-transit | Ical Ex | resulting in death) Last Due t | o (or as a consequence of): | |
| Box 68 | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | n/Medi | | outcome of pregnancy | 23d. Date of delivery |
| P.O. B | the death y the atte ched for | by Physician/Med | | gnant at time of death 5 🗆 Other (specify) | Month Day Year |
| | w requires that the deben signed by the should be detached | by Pt | Part II. Other significant conditions contributing to | death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? 1 ™Yes 2 □ No 3 □ Probably 4 □Unknown |
| Records, | law requ as been 2 should | Completed | Lung Mass | | 24a. Was an autopsy findings available prior to completion of cause of |
| | ding Physician: The law h. After this certificate has t funeral director, page 2 s | е Сош | 25. Was case referred to medical | 26 Place of Death | performed? death? 1 Yes 2 No 1 Yes 2 No |
| of Vil | Physician: r this certifica and director, I | To B | examiner? 1 Yes 2 No Hospital: 1 | Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Ho | ome 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred |
| Division of Vital | Attending P r death. ector: After t by the funera | atlon: | 2 Accident investigation | onth, đay Year) Injury Work? M 1 Yes 2 No | |
| Divis | after de Directo | Certification: | 3 Suicide 6 Could not be determined bu | ce of Injury - At home, farm, street, factory, office Iding, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Medical C | (Check only 2 Medical Examiner: On the | he best of my knowledge, death occurred at the time, date and place, basis of examination and/or investigation, in my opinion, death occurrance stated. | and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s) |
| | To the within ? | Me | 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
| | DX | | 30. Name and address of person who completed ca | uuse of death (Item 23a) (Type, Print) | 1-17-10-0 |
| | St | ate | Robert J. Reilly MD 31. Date filed (Month, Day, Year) 32 | 560 Riverside Or. Blot Salis Registrar's Signature | sbury mas Elsey |
| Di | Regist | rar | NOV 0 9 2006 | be best of my knowledge, death occurred at the time, date and place, obasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, obasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, obasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, obasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, obasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, obasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, obasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, obasis of examination and/or investigation, in my opinion, death occurred at the time, date of examination and/or investigation, in my opinion, death occurred at the time, date of examination and/or investigation, in my opinion, death occurred at the time, date of examination and/or investigation, in my opinion, death occurred at the time, date of examination and/or investigation, in my opinion, death occurred at the time, date of examination and/or investigation, in my opinion, death occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of | |
| ٦٢ | (7 TIEV (/Z | .001 | | ORIGINAL | |

| | | | For State Registrar | State of M | /larylan | | irtment of tificate o | | | | iene eg. No. | 06 | 37882 |
|-----------------------------|---|-----------------|---|------------------------------------|--------------------------------|--|------------------------------------|----------------------|--------------------|----------------------------------|----------------------------|---------------------------------|---------------------------------|
| | | | Decedent's Name (First, Middle, Las | t) | | | | | | 2. Date of Dea | th | | 3. Time of Death |
| | Physicia | | NELDA | S. | COC | HRAN | | | | NOV. | 13 | Year 2006 | 10:45 A M |
| | /Medic Examin | | 4a. Facility Name (If not institution, give | street and numbe | | | 4b. City, Town | n, or Location | of Death | 11011 | | nty of Death | 10.43 A |
| | A . | | ATLANTIC GENER | AL HOSPIT | AL | | BER | LIN | | | WO | RCESTE | CR. |
| 4 | Funeral | | 5. Social Security Number 6. S | | Age (In yrs. I | ast birthday) | If Under 1 Yes | ar If Unde | or 24 Hrs. Min. | 8. Date of Birth (Month, Day | 1 | | place (State or Foreign |
| ~ | Director | | 160-20-1005 | □M 2 🖾 F | 80 | Yrs. | IVIOITATO DAY | 73 | 141111 | APRIL 3 | , 1926 | PENN | SYLVANIA |
| ġ. | and w | | Usual Residence of Decedent 10a. State 10b. County | | 10c City | , Town or Lo | cation | | | | | | 10d. Inside City Limits |
|) | sho | 5 | | DD GTEN | | | | | | | | | 1 ☐ Yes 2X No |
| 0 | the Marylar 28a-f show | Director | MARYLAND BALTIMO | RE CITY | B | ALTIMO | RE 10f. Zip Code | | | | 0g. Citizen o | of Milhot Cour | |
| 5 | death with the Maryland ms 23e or 28e-f show rmast be routified at | ā | 4221 HARCOURT R | 1 A D | | | | | | | | | nu y r |
| * | items 23e | Funerai | 11. Marital Status | 12. Was Deceder | nt Ever in U. | S. 13. v | | 214 of Hispanic C | rigin? (Spe | ecify Yes or No- | | SA ace - Americ | can Indian. |
| 7 6 | r iter | ᇤ | 1 ☐ Never Married 2 ☐ Married | Armed Forces | | | | | | ecify Yes or No- Rican, etc.) | В | lack, White, | |
| - 26 21215-0036 | within 72 hours after ene. than "natural", or ite ha Medical Evanilina | by | 3 XWidowed 4 ☐ Divorced | If Yes, Give Year or Dates | : | 1 | ☐Yes 2X11 | No Specif | y: | | Spec | ify: WH | ITE |
| 200 | 72 ho natur ilical | Completed | 15. Decedent's Ed (Specify only highest gra | ucation | | 16a. Deced | ent's Usual Occ | cupation | act of worki | na | 16b. Kind of | Business/In | dustry |
| 202 | ithin le. | nple | Elementary/Secondary (0-12) | College (1-4o | r 5+) | life. L | kind of work dor OO NOT use ret | | Jai OI WOIKII | ng . | | | |
| | filed w Hygier other th | Co | | 2 | | | NURSE | | | | | LTHCAR | E |
| 17 × × × | 2 should be filed within 72 hours aft and Mental Hygiene. Is marked other than "natural", or sumatic event, the Medical Evami | Be | 17. Father's Name (First, Middle, Last) | | | | | 18. Moti | | (First, Middle, | | | |
| 3 1 6 | nould I Mer narke | 2 | HARRY | SIVITS | | | | | DAISY | | (UNKNO | | |
| 710 11 14-03 Maryland | d 2 sh h and 7 Is rr traun | | 19a. Informant's Name/Relationship (7) KEITH N. COCHRAN | | | ¥ | | | | I Route Number | | | |
| 10 | ges 1 and 2 should be filed within 72 hours after death with the Maryla t of Health and Mental Hygiene. If item 27 Is marked other than "natural, or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be rediffed at | | 20a. Method of Disposition | BON | | ace of Dispos | sition (Name of | | | RGETOWN, | DELAV 20c. Location | | |
| OCH P OCB Baltimore, | ages nt of t: If it | | 1 ☐ Burial 2 X Cremation 3 ☐ | | 9 | | natory or other p | | | | | | |
| なの間 | nit. P artme ortan injury | | 4 □ Donation 5 □ Other (Specify 21. Signature of uneral Service Licen | | CKE | | OF DEI | | | 4/06 | DELMA | R, DE | LAWARE |
| 7 8 | permit. Pages 1 and 2 Department of Health a Important: If item 27 It any injury or other tra | | 1 Kuller W | tust | - | | | | | ME,SELE | YVTI.I.F | E. DE. | 19975 |
| | | | 23a. Part 1 Enter the disease, or comp shock, or heart failure. List only | plications that eaus | ed the death | | | | | | | , , , | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | < | SIR |) <t<< td=""><td>5</td><td></td><td></td><td></td><td></td><td></td><td>Onset and Death</td></t<<> | 5 | | | | | | Onset and Death |
| | /Medical | | resulting in death) | a. Due to for | s a consequ | ence of): | 0 1 / | 7 | Λ | | | | |
| | Examiner | | Sequentially list conditions | b. — (7) | ock | oras | ted bo | mun | el | | | | |
| | ₽ # | iner | Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury | Due to (or a | s a consequ | ence of): | | | | | | | |
| | be executed ician and burial-transit | Examiner | that initiated events resulting in death) Last | C | | | | | | | | | |
| 777 8760, | be ex cian | i E | | Due to (or a | is a consequ | ience or): | | | | | | | |
| 171 | cate phys | dicai | | d | | | | | | | | | |
| , UX | certifi iding ise as | /Me | IF FEMALE: | 23c. If yes, outcom | ne of pregna | ncv | - | | | | 224 [| Data of dollar | |
| 2 28 | ires that the death certifi signed by the attending d be detached for use as | by Physician/Me | 23b. Was decedent pregnant in the past 12 months? | 1 ☐ Live birth 4 ☐ Pregnant | 2 🗌 Fetal | death 3 | Ectopic pregnal Other (specify) | | | | | Date of delive Month | Day Year |
| 03 | the d y the | ysi | 1 Yes 2 No 9 Unknown | 9☐ Unknown | | | , oo. (oposy) | | | | | | |
| 0 -0 | s that | y PI | Part II. Dther significant conditions of | ontributing to death | but not resu | ulting in the un | derlying cause | given in Part | t I. | 23e. Did to | bacco use co | ntribute to th | ne cause of death? |
| rds | Attending Physicien: The law requires that the robath. r death. sctor: After this certificate has been signed by the the funeral director, page 2 should be detache | | | | | | | | | 1 □ Y | es 💥 No | 3 🗆 Prob | pably 4 Unknown |
| 700) Recor | s been si s been si s should | Completed | | | | | | | | 24a. Was a | | . Were auto | psy findings available |
| H & | ysicien: The lav is certificate has director, page 2 | mo | | | | | | | | autops perfor | Tied? | prior to co death? 1 Yes | mpletion of cause of |
| ital | icien: Th certificate rector, pag | Bec | 25. Was case referred to medical | | | | | 26. Plac | ce of Death | (Check only or | 1 | 1 1 1 1 1 1 1 | 2010 |
| > | Physic this ce al direc | ToE | examiner? 1 Tes 2 No | Hospital: Inpa | tient 2 🗆 I | ER/Outpatien | 3 DOA | Other: 4 🗆 N | Nursing Hor | me 5 ☐ Reside | ence 6 □0 | ther (Specif | y) |
| 0 | ding Ph h. After thi funeral | :uo | 27. Manner of Death 1 ☐ Natural 5 ☐ Pending | 28a. Date of In (Month, L | jury Day Year) | 28b. Time of Injury | 28c. In | ijury at Vork? | 2 | 28d. Describe h | ow injury occi | urred | |
| Sio | death. ctor: A y the fu | cati | 2 ☐ Accident investigation | | | | | Yes 2 | □No | | | | |
| Division of Vital | or Att | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of I | njury - At ho etc. (Specify | me, farm, stre | et, factory, offic | CO CO | 4 | 28f. Location (S. City or Town | treet and Num n, State) | nber or Rura | I Route Number, |
| u | Hospitel 24 hours a Funerel I | | 29a. Certifier 1 Certifying Ph | vsician: To the hes | st of my know | wledge death | occurred at the | time date | and place 5 | and due to the c | auso(s) and | mannar an a | totad |
| | To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the | edical | 29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example | niner: On the basis and manner: | of examinat stated. | ion and/or inv | estigation, in m | y opinion, de | eath occurre | ed at the time, d | ate and place | and due to | the cause(s) |
| | To the within 2 To the comple | Me | 29b. Signature and title of entifier | | | | 29c. Lice | ense number | 1 | 2 | 9d. Date sign | ned (Month, | Day, Year) |
| | 63 | |) / , | 1. M | 1 | | DG | 455 | 35 | | 11/10 | 3/06 | |
| | 28 | | 30. Name and address per v | mp eted cause of | death (Item | 23а) (Туре, | | | | | | | - A: |
| - | יח | | ANTHONY BI | CKELL | Ami | 0 9 | 733 | HEAL | -TH W | AyDR | B | remi | 16/21811 |
| | Sta Registr | 4 | 31. Date filed (Month, Day Year) NOV 1 4 2 | | strar's Signat | | | | | | | | |
| | Registi | ar | 1101 147 | UUU JOHN | UR 1 | H. A | andi) | | | | | | |

| | | | For State Registrar | State of M | larylan | | artment | | | and M | | giene Reg. No.2 | 106 | 37883 | |
|-------------------|--|------------------|--|--|----------------------------|--------------------------------|--|-------------------------|---------------------------|------------------------|--|------------------------|----------------------------|--|---|
| | | | Decedent's Name (First, Middle | B, Last) | | | | | | | 2. Date of De | ath | | 3. Time of Death | _ |
| | Physicia | | Louise | M. | C | olmer | | | | | Month | Day | Ob | 1900 M | |
|): | /Medic Examin | | 4a. Facility Name (If not institution | n, give street and number, |) | | 4b. City, | Town, or | Location o | of Death | | | nty of Death | | Т |
| | | | WMHS-13rd | - 1001001 - | amp | us | Cur | nbe | erla | na | | HII | egar | | |
| | Funeral | | 5. Social Security Number | 6. Sex 7. A | | ast birthday) Yrs. | If Under Months | 1 Year Days | If Under : | 24 Hrs. Min. | 8. Date of Bir (Month, Da Oct 7, | th y, Year) 1001 | 9. Birth Cou | place (State or Foreign | |
| | Director | - | 204-16-6283 Usual Residence of Decedent | | 85 | 113. | | | | | Oct 7, | 1921 | | r A | _ |
| | /land | } | 10a. State 10b. County | | 10c. City | , Town or La | | | | | | | | 10d. Inside City Limits | |
| | Mar | ţ | WV Mine | eral | | Ridge | eley | | | | | | i | 1 ☐ Yes 2√☐ No | |
| | or 28 | lre | 10e. Street and Number | | | | 10f. Zip | | | | | 10g. Citizen o | | ntry? | |
| | 23a | Funeral Director | Route 2 Box 51 | | | | | | 26753 | | | | JSA | | |
| | er de | nue | 11. Marital Status | 12. Was Decedent | ? | S. 13. | Was Deced If Yes, spec | ent of His ify Cubar | spanic Orig n, Mexican | gin? (Spe i, Puerto | cify Yes or No Rican, etc.) | - 14. R | ace - Ameri lack, White | | |
| 5 | rs aft | by F | 1 ☐ Never Married 2 ☐ Marr 3 🛣 Widowed 4 ☐ Divorced | If Vas Give | | | 1□Yes 2 | No | Specify: | | | Spec | ^{cify:} whi | te | |
| 3215-0036 | filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene Hygiene wither than "natural", or itema 23a or 28a-f show ant, the Madical Examiner must be notified at | | | t's Education | | 16a. Dece | dent's Usua | Occupa | ition | | | 16b. Kind of | | | _ |
| 2 2 2 | hin 7 | pie | (Specify only highes Elementary/Secondary (0-12) | st grade completed) College (1-4or | 5+) | | kind of wor DO NOT us | | | t of worki | ng | | | | |
| 7 | od wit | Completed | 12 | | | Nursir | ng Ass | | | | | Nursin | | ne | _ |
| ח | 0 = 0 > | Be | 17. Father's Name (First, Middle, | | | | | | 18. Mothe | | e (First, Middle, Benedic | | ame) | | |
| $\frac{2}{3}$ | should be ind Mental s marked o | P P | Harry Benedi | | | 105 Maille | | /Ct-na4 a | | | | | - Ctata 7 | - Codel | |
| Ž | permit. Peges 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once. | | 19a. Informant's Name/Relations Annette Humbe | | ghter | 102 | 5 Wei | res A | Avenu | je | LaVa | le | M, State, Zi | D 21502 | |
| Baltimore, | is 1 and 1 a | | 20a. Method of Disposition | | 20b. P | lace of Dispo emetery, crer | sition (Nam | ne of ther place | 9) | | ate | 20c. Location | | own, State | |
| Ē | Peges nent of ant: if it ary or o | | 1 ☐ Mourial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S | | Min | eral Ba | otisť Ch | urch | Ceme | tery | 11/20/200 | ⁶ Fort A | ∖shby | WV | |
| at | prmit. | | 21. Signa of Funeral Service | Licensee | 1 | 22 | Name and | d Addres arpell | s of Facilit | ral Ho | ome, PA | | | | |
| | 207 29 | | THOMA | TUCULE | W | | 108 | 8 Virg | jinia A | venue | : Cumbe | | D 2150 | | _ |
| | | | 23a. Part1. Enter the disease, or shock, or heart failure. List | complications that ciliuse only one cause on each | ed the death line. | n. Do not ent | ter the mode | e of dying | g, such as | cardiac c | or respiratory a | rrest, | | Approximate Interval Between Onset and Death | |
|) | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a. ARTE | rio | SCLE | LOTI | c (| CAM | Ve je | ASCUL | m Diz | EMSE | YRS | |
| H | Examiner | ; | , | Due to (or as | | | ı | | | | | | | YRS | |
| | 1 | er | Sequentially list conditions, if any, leading to immediate | b. 147PE | | | | | | | | | | N 16-2 | |
| V | uted d ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | 6 | | | | | | | | | | | |
| ó | be executed sicien and burial-transit | Еха | resulting in death) Last | Due to (or as | s a consequ | uence of): | | | | | | | | | |
| 3760, | ate | licai | | d. | | | | | | | | | | | _ |
| ğ × | eeth certifica attending ph | Physician/Med | IF FEMALE: | 23e Hwas outcom | o of progna | nov. | | | | | | | | | |
| Вох | attend for us | ian/ | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome 1☐Live birth 4☐Pregnant a | 2 Feta | death 3 | Ectopic pro | | | | | | Date of deliv Month | rery Day Year | |
| o | of the de by the a | ysic | 1 □ Yes 2 □ No 9 □ Unknown | 9□ Unknown | at time or or | 94U1 J. | _ Other (spe | sciiy) | | | | | | | |
| <u> </u> | res thet igned by be deta | | Part II. Other significant condition | ons contributing to death | but not resi | ulting in the u | nderlying ca | ause give | n in Part I. | | 23e. Did t | obacco use co | ontribute to | the cause of death? | |
| rds | w requires been sig should be | ed by | | cidne & c | | | | 65 | | | | Yes 2 No | 3 □ Pro | bably 4 Unknown | |
| Records, | aw re | Completed | LEFT VEN | Tricuca | <u> </u> | YSTOL | ic 1 | L-Ma | 46 | Airu | 24a. Was | an 24t | o. Were aut | opsy findings available ompletion of cause of | |
| Ĕ | sician: The law s certificate hes t lirector, page 2 s | E O | | | | | | | | | | rmed? | death? | 2□ No | |
| ita | cian: ertific ictor, | Be (| 25. Was case referred to medica examiner? | | | | | | | of Death | (Check only o | one) | | | _ |
| 5 | Physic this c | 2 | 1 ☐ Yes 2 No | Hospital: 12 Inpat | | ER/Outpatier | | | 4 🗆 Nu | | me 5□Resi | | | fy) | _ |
| ב | ding P | ion | 27. Manner of Death 1 Natural 5 □ Pendir | | lay Year) | 28b. Time o Injury | M 2 | 8c. Injury Work | rat ⊲? Yes 2 🔲 I | | 28d. Describe | now injury occ | urrea | | |
| Division of Vital | or Attending Physician: ifter death. Director: After this certifica in by the funeral director, | ficat | 2 Accident investi | not be 200 Place of Ir | niury - At ho | me, farm, str | | | | | 28f. Location (| Street and Nur | mber or Rui | al Route Number, | _ |
| ≧ | after after 1 Dire d in b | Certification: | 4 Homicide | building, e | etc. (Specif | v) | | | | | City or To | wn, State) | | | p |
| | To the Hospitel or Attendit within 24 hours after death. To the Funerel Director; A completely filled in by the fu | | (Check only 2 Medical | ng Physician: To the bes Examiner: On the basis | at of my kno of examina | wledge, deat tion and/or in | h occurred a | at the tim | e, date an pinion, dea | d place, | and due to the | cause(s) and i | manner as: | stated. to the cause(s) | _ |
| | To the Mithin 24 | Medicai | one) 29b. Signature and title of certifie | and manner s | stated. | | | | number | | | 29d. Date sign | | <u> </u> | _ |
| | £.₹8 | | 1 | | Jones | ll | 440 | | | ال | 7 | | | | |
| • | 10 | | 30. Name and address of person | who completed cause of | death (Item | 1 23a) (Type, | Print) | | - | | ` ' | 100 | - | - 10 | |
| | 1 - | | Gregg Dona | | M.D | 1. 9 | 12 | Set | ton | Dr | ive C | um be | -land | l, MO. | |
| | Sta | | 31. Date filed (Month, Day, Year) | 32 negis | trar's Signa | ture | 24/2 | , | | | | | | | |
| | Registr | | | LOODE ME | 11 · 1 | r MAZ | THE STATE OF THE S | | | | | | | | |

| 1 - For State Registrar | State of Maryland / | Department of He | | Hygiene | 6 37884 |
|--|---|---|--|--|---|
| 1. Decedent's Name (First, M. | iddle, Last) | | 2. Date | of Death | 3. Time of Death |
| Physician MIRIAM GUS! | TAVIA MARTIN DURH | IAM | Mont 1 | | 6 1825 M |
| Examiner 4a. Fecility Name (If not institu | ution, give street and number) | 4b. City, Town, or I | | 4c. County of | |
| 5 Copiel Coqueity Number | GE S HOSPITAL CEN 6. Sex 7. Age (In yrs. last) | | ERLY If Under 24 Hrs. 8. Date | PRINCE | GEORGE 'S Birthplace (State or Foreign |
| Funeral 216-32-9439 | 1□ M 2□XF 70 | Months Days | Hours Min. (Mon: FEB | th, Day, Year) | Country) N.C. |
| Usual Residence of Decedent | | own or Location | | | 10d. Inside City Limits |
| 10a. State 10b. Cou | | | | | 1X Yes 2 □ No |
| the Marital Status 10a. State 10b. Country 10a. State 10b. Country 10a. State 10b. Country 10a. State 10b. Country 10b. Country 10c. Street and Number 224 N. MOUTRY 11. Marital Status | BAL | TIMORE 10f. Zip Code | | 10g. Citizen of Wha | it Country? |
| 224 N. MO | UNT ST., | 21223 | | UNITED | STATES |
| 224 N. MOU | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of His If Yes, specify Cuban | panic Origin? (Specify Yes , Mexican, Puerto Rican, et | or No- 14. Race - | American Indian, White, etc. |
| D | If Yes Give | 1 ☐ Yes 2☐xNo | Specify: | | LACK |
| 10a. State 10b. Councillation 10a. State 10b. Councillation 10a. State 10b. Councillation 10a. State 10b. Councillation 10a. State 10b. Councillation 10a. State 10b. Councillation 10b. Councillation 10c. Street and Number 224 N. MOI 11. Marital Status 1 Never Married 2 Never Marr | dent's Education 16 | 6a. Decedent's Usual Occupat | tion | 16b. Kind of Busin | |
| Specify only his specific only his spe | ghest grade completed) 2) College (1-4or 5+) | (Give kind of work done du life. DO NOT use retired) | uring most of working | | |
| 12th | | | CLERK | PRIVA | OE . |
| D = 1 5 5 0 17. Father's Name (First, Midd | | | 18. Mother's Name (First, M AUGUSTA | fiddle, Maiden Sumame) RAMSAY | |
| DOEL MART | | 19b. Mailing Address (Street ar | | | te. Zip Code) |
| E SECT DONALD DUR | 1111 | 9114 TAMDOM | | susception are solved. | -0.0 |
| O - I 5 € 20a Method of Disposition | 20b. Place | e of Disposition (Name of etery, crematory or other place | Date | 20c. Location - Cit | y or Town, State |
| E d e e e e e e e e e e e e e e e e e e | ion 3 Hemoval from State | APEAKE CREM. | | | ILLE, MD |
| 21. Signature i Funeral Sen | rice Cans of State State | 22. Name and Address CAPITOL M. | of Facility IORTUARY 14 | WASH., D 25 MARYLAN | |
| 23a. Part1. Enter the disease shock, or heart failure. | or complications that caused the death. Constitution is only one cause on each line. | not enter the mode of dying | , such as cardiac or respira | tory arrest, | Approximate Interval Between |
| Physician disease or condition | myor | condial a | forctio | ~ | Onset and Death |
| /Medical resulting in death) Examiner | Due to (or as a consequent | ge of): | 0 | - 1 | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or as a consequence | ce of): | or acco | in | |
| Cause (Disease or injury that initiated events resulting in death) Last | 1 | | | | |
| cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence | ce of): | | | |
| ate ate ate | d | | | | |
| 0 = 2 0 | 23c. If yes, outcome of pregnancy | , | | 23d. Date of | f dollaron |
| The season of th | 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death | ath 3 □Ectopic pregnancy | | Z3d. Date of Month | Day Year |
| O et 1 2 S No 9 Unknown 9 Unknown | 9□ Unknown | | | | |
| > Part II. Other significant con | ditions contributing to death but not resulting | g in the underlying cause given | n in Part I. 23e. | Did tobacco use contribu | te to the cause of death? |
| law requires as been sign as been sign as been sign pleted b | englishing | | | 1 Yes 2 No 3(| Probably 4 Unknown |
| 0 5 0 0 0 | orgula per org | | 24a. | autopsy prio | r to completion of cause of |
| Tank and the second sec | | | | | Yes 2 No |
| Attending Physician: Attending Physician: Attending Physician: Attending Physician: Attending Physician: Accepting Accepting Accepting Physician: A | Hospital: | /Outpatient 3 DOA Other | 26. Place of Death (Check 1. 4 □ Nursing Home 5 □ | | (Coanty) |
| O THE SECTION OF THE | 28a. Date of Injury 28t | b. Time of Injury Work | | cribe how injury occurred | Specify) |
| A Cocident inv | restigation | | es 2□No | | |
| Certiff Cash. 2. Wadue of Description: Safet death. Saf | 28e. Place of Injury - At home building, etc. (Specify) | , farm, street, factory, office | 28f. Loca City | tion (Street and Number or Town, State) | or Rural Route Number, |
| 29a. Certifier 12€ Cert | ifying Physician: To the best of my knowled ical Examiner: On the basis of examination and manner stated. | dge, death occurred at the time and/or investigation, in my op | e, date and place, and due t inion, death occurred at the | to the cause(s) and mannetime, date and place, and | er as stated. due to the cause(s) |
| 29b. Signature and The of cer | | 29c. License | number | 29d. Date signed (| Month, Day, Year) |
| 1 Jan | es Ohias MI | D D | 45341 | Novemb | 2 12,2006 |
| | son who completed cause of death (Item 23 Wes | Prince Geor | ge Hospital | 3001 H | getal Drive |
| State Registrar 31. Date filed (Month, Day, Y | | B | , | Cheved | 91 MD |

| | | | For State Registrar | State of M | <i>l</i> larylar | | artment o | | | ind M | | giene og. No. 0 | 06 | 378 | 85 |
|--------------------------------|---|----------------|---|--|----------------------------|----------------------------------|-------------------|--------------|------------------|------------|---|--------------------|---------------------|---|--------------|
| | Dharini | | 1. Decedent's Name (First, Middle, L | .ast) | | | | | | | 2. Date of Dea Month | th Day | Year | 3. Time of | Death |
| | Physicia /Medic | | Ana Christina | Duarte | | | | | | | Novemb | er 5, 2 | 006 | 12:27 | ам |
| | Examin | | 4a. Facility Name (If not institution, g | | | | 4b. City, To | | | f Death | | 4c. County | | | |
| | | | Montgomery Gene | - | | (not high doub | If Under 1 | | Olney If Under 2 | 04 Hrs | 8. Date of Birth | | tgom | | |
| | Funeral Director | | 5. Social Security Number 6. 577–15–4338 | Sex 7. / 1 ☐ M 2 ☐ ¥F | 38 age (III yrs. | last birthday) Yrs. | | Days | Hours | Min. | Month, Day July 22 | Year) 1968 | Co | nplace (State o. untry) :temala | r i-oreign |
| | | | Usual Residence of Decedent | | | | | | | | , | , 2300 | | | |
| | how | | 10a. State 10b. County | | 10c. Ci | ty, Town or Lo | | _ | | | | | | 10d. Inside Cit | - |
| | Be-f | cto | Maryland Montgo | mery | | БГОС | kevill | .e | | _ | · · · · · · · · · · · · · · · · · · · | | | 1 🗆 Yes | 24 No |
| | /ith th | Director | 10e. Street and Number | | | | 10f. Zip Co | | | | 1 | 10g. Citizen of | | untry? | |
| | s 23e | srai | 2527 Sutcliff T | | at Europia II | 10 12 | Mas Decedes | | 0833 | in 2 (Coo. | oifu Vac ar Na | | USA | ncan Indian, | |
| | ter de | Funerai | 11. Marital Status 1 X Never Married 2 Married | 12. Was Decede Armed Force 1 ☐ Yes 2 [| s? | 7.5. | If Yes, specify | Cubar | n, Mexican | , Puerto F | cify Yes or No- Rican, etc.) | | ck, White | e, etc. | |
| 920 | urs af | by | 3 ☐Widowed 4 ☐ Divorced | If Yes, Give Year or Date: | _ | | 1X Yes 2□ | No | Specify: (| Guate | emalan | Specif | y: Wh | ite | |
| Ď. | be filed within 72 hours after death with the Maryland Hygiene. At Hygiene. Ad other then "neture!", or items 23a or 28e-f ehow event, ite Medical Examinar must be colified at event, ite Medical Examinar must be colified at | Completed | 15. Decedent's (Specify only highest of | Education | | 16a. Dece | dent's Usual (| Occupa | ition | of workin | ng. | 16b. Kind of B | usiness/l | ndustry | |
| 21 | ithin 199. | npie | Elementary/Secondary (0-12) | College (1-4c | or 5+) | life. | DO NOT use | retired) |) | | ·9 | | | _ | |
| 2 | filed wil Hygien other th | | 47 Fabrus Name (First Middle) | 2 | | | Ooctor' | | | | /Fire A. A Airdelle | | ledic | al | |
| - | m = 0 = | Be | 17. Father's Name (First, Middle, La. Alvaro Duarte | sr) | | | | | | | (First, Middle, a J. Ga: | | ne) | | |
| Ž | 2 should be and Mental ie marked raumatic ev | ၀ | 19a. Informant's Name/Relationship | (Type Print) | | 19b Mailir | ng Address (S | itreet a | | | Route Number | | State 7 | in Code) | |
| <u>8</u> | trau | | Jessica C. Duart | | 0.16 | | | | | | 3rookev | | | | |
| ē, | permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any Injury or other traumatic evonce. | | 20a. Method of Disposition | | 20b. F | Place of Dispo cemetery, crer | | | -1 | Di | ate | 20c. Location | | | |
| Ē | Pages nent of ant: If it | | 1 ☐ Burial 全 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special | | (B) | ropolita | | | TINE | ovemb | er 8, 2006 - | Alexan | deri n | Winai | ini a |
| Baltimore, Maryland 21215-0036 | mit. partm porte y Inju | | 21. Signature of Funeral Service Lic | ensee | | F1 | Name and A | Addres | s of Facility | ins I | Zuneral | Home I | nc. | , virgi | 11111 |
| <u> </u> | 89 = 9 | | Hames & | Dooly | | 50 | 00 Univ | ers | sity 1 | Blvd, | , W, Si | lver Sp | ring | , MD 20 | 0901 |
| | | | 23a. Part1. Enter the disease, or co shock, or heart failure. List on | mplications that cab ly one cause on each | ed the deat line. | th. Do not ent | er the mode o | of dying | g, such as o | cardiac or | respiratory arr | est, | | Approximate Interval Bety Onset and D | ween |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | a. Hemoi | ytiz | Anes | nia | | | | | | | day | 5 |
| | /Medical Examiner | | resulting in death) | Due to (or | as a consec | quence of): | | | | | | | | | |
| | | e | Sequentially list conditions, | b. — Due to for | 35 & 3J 1530 | rusnes off: | | | | - | | | | | |
| | uted d | Examin | Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | | | | |
| Ó | exec en an | | resulting in death) Last | CDue to (or a | as a consec | quence of): | | | | | | | | | |
| 8760 | cate be executed by sicien and the burial-transit | dicai | | d | | | | | | | | | | | |
| 39 | artifica ing pt e as ti | Med | IF FEMALE: | | | | | | | | | | | | |
| Вох | The law requires that the death certific tie hes been signed by the attending p bage 2 should be detached for use as t | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcom 1☐Live birth | 2 Feta | aldeath 3 [| Ectopic preg | | | | | T | te of deli- | | ear ear |
| o O | at the de by the a tached f | ysic | 1 ☐ Yes 2 🛣 No 9 ☐ Unknown | 4☐Pregnant 9☐ Unknown | | leath 5 | Other (spec | ify) | | | | | | , | |
| P.0 | res that ti igned by be detac | | Part II. Other significant conditions | contributing to death | but not res | sulting in the u | nderlying cau: | se give | n in Part I. | | 23e. Did to | bacco use con | tribute to | the cause of d | eath? |
| Sp | puires n sign ald be | d by | | | | | | | | | 1 🗆 Y | es 250No | 3 🗆 Pro | bably 4 🗆 U | Inknown |
| S | s been si | olete | | | | | | | | | 24a. Was a | | Were aut | opsy findings a | available |
| æ | The lav | Completed | | | | | | | | | autops perfor | med? | death? | ompletion of ca 2□ No | luse of |
| ita | | BeC | 25. Was case referred to medical examiner? | | | | | | 26. Place | of Death | Check only or | | - 4-1-1-1 | | |
| <u>></u> | Physic this ce | ို | 1 ☐ Yes 2 No | Hospital: 1 X npa | | ER/Outpatier | | Othe | 4 🗆 1901 | | ne 5 ☐ Reside | | | ify) | |
| D C | ding P h. After I funera | ion: | 27. Manner of Death 1. Natural 5 ☐ Pending | 28a. Date of Ir (Month, I | njury Da <i>y Year)</i> | 28b. Time of Injury | | Mork Work | | | 8d. Describe h | ow injury occur | red | | |
| Division of Vital Records, | teat tor: the | icat | 2 Accident investigat 3 Suicide 6 Could not | be goo Gleen of | Iniuge . At h | ome farm etr | M Part factors of | | /es 2□N | | 8f. Location (Si | treet and Numi | ner or Pu | m / Poute Num | har |
| <u>≥</u> | I or Atten after deatl Director: I in by the | Certification: | 4 Homicide determine | building, | etc. (Specia | fy) | eet, factory, o | ilicə | | - | City or Town | | <i>761 01 11</i> 0. | a route vulli | <i>J</i> 67, |
| | To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by | | 2.82 Certifier Certifying | Physiciam To the be | at of my km. | rwladge, death | n periund at | tha tim | 6: date and | d placa, a | nd due to the e | ausa(s) and mi | BETTER DE | statud. | |
| | To the Ho within 24 I To the Fu completely | edicai | (Check only Amedical Ex | aminer: On the basis and manner | s of examina stated. | ation and/or in | vestigation, in | my op | inion, deat | h occurre | d at the time, d | ate and place, | and due | to the cause(s | |
| | To the within 2 To the complete | Σ | 29b. Signature and title of certifier | 2 - / | | | 29c. L | icense | number | | - 2 | 9d. Date signe | | | |
| | | 0.0 | PI Nelisol 1. | Zon 216 | | | _ | שטכ | 136- | 165 | | 11/0 | +/2 | 006 | |
| - | > | | 29b. Signature and title of certifier Pulson for 30. Name and address of person wh Melisca Piuzku 31. Date filed (Month, Day, Year) NOV 08 | o completed cause o | f death (Iter | п 23а) (Туре, | Print) | 10 | ni. | ž. | 000 | 29 | | | |
| | Cir | +0 | 31. Date filed (Month, Day, Year) | 32.8eqi | Strar's Signa | ature _ | PUN | ie, | VIne | 5 1 | 10 308 | 52 | | | |
| | Sta Registr | | NOV 08 | 2006 | urs s | K A | sells. | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 9:15 PM SY DANG NOVEMBER 11, 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min 1 X M 2 □ F Yrs. JULY 29, 1929 VIETNAM 213-96-7309 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County f show 7 is marked other than "natural", or itams 23s or 28s-f sho traumatic event, the Michigal Examinar must be notified at 1 ☐ Yes 2 X No SILVER SPRING Director MARYLAND MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 U.S.A. 12808 TIMBERVIEW COURT death Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify ASIAN þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 72 (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CATHOLIC CHARITIES SOCIAL COUNSELOR 12 should be filed w and Mental Hygier 7 is mark≡d other tf 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be TY THI HO ٥ CANH DANG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: if item 27 is 13734 NOTLEY ROAD, SILVER SPRING, MARYLAND 20904 HONG PHAN - DAUGHTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ Department of important: if any injury or one. 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN CEMETERY 11/18/2006 SILVER SPRING, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HOURS **Physician** SEPTIC SHOCK WITH LACTIC ACIDOSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed physicien end s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ HEPATITUS C 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b director, page 2 s 2 🖾 No 1 Yes Attending Physicien: director, 26. Place of Death | Check only one Be 25. Was case referred to medical Hospital: Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပ္ 1 ☐ Yes 2 💢 No 1 XInpatient s after deam.
el Director: After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Certification: 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after 1 To the Funeral Direction filled in by 4 Thomicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert NOVEMBER 12, 2006 D26540 person who completed cause death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

CARL I. SCHOENBERGER, M.D.,

NOV 14

32

2006

₽egistrar's Signature

31. Date filed (Month, Day, Year)

Bat 2 3A (at 10. 2. Terry)

16220 FREDERICK ROAD, SUITE 213, GAITHERSBURG, MARYLAND 20877

| | | | For State State Registrar | ite of Maryland | | artment of H rtificate of I | | | ene g. No2 0 0 6 | 37887 |
|----------------|--|----------------|--|---|----------------------|--|--|--|---|---|
| ı | Physicia | an | 1. Decedent's Name (First, Middle, Last) FRANCIS FREDERICK | DAHLER | | | | 2. Date of Death Month Novembe | | 3. Time of Death 9:30 A M |
| | /Medic Examin | | 4a. Facility Name (If not institution, give street a | and number) | | 4b. City, Town, or | r Location of Death | | 4c. County of Death | |
| , | * | • | FREDERICK MEMORIAL | | | FREDEF | | | FREDER | |
| | Funeral Director | | 5. Social Security Number 6. Sex 1 № M 2 17-42-0170 1 № M 2 Usual Residence of Decedent | 7. Age (In yrs. la | st birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Dec. 24 | Year) 9. Birth Con Man | place (State or Foreign intry) cyland |
| | land ow | | 10a. State 10b. County | 10c. City, | Town or Lo | cation | | | | 10d. Inside City Limits |
| | Mary | tor | Maryland Frederick | | Mt. | Airy | | _ | | 1 ☐ Yes 2 No |
| | ith the | Directo | 10e. Street and Number | | | 10f. Zip Code | | 10 | g. Citizen of What Cou | • |
| | ath w | | 13786 Blythedale Dri | Ve as Decedent Ever in U.S | 10 | Mas Decedent of H | 21771 | acity Vac or No. | United S | |
| 5-0036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heatlih and Mertal Hydjene. If Hem 27 is marked other than "natural", or Items 23a or 28a-f show If Hem 27 is marked other than "natural", or Items 20 so 728a-f show or other traumatic event, the Medical Examiner must be notified at | by Funeral | 1 ☐ Never Married 2 ☑ Married 1 [If] | as Decedent Ever in 6.5 med Forces? ∏Yes 2⊠ No ⁄es, Give ar or Dates: | | of Yes, specify Cuba 1 ☐ Yes 2 ☑ No | lispanic Origin? (Spi an, Mexican, Puerto Specify: | Rican, etc.) | Black, White | |
| 2 2 | 72 ho 'natur dical | Completed | 15. Decedent's Education (Specify only highest grade com | oleted) | 16a. Dece | dent's Usual Occup kind of work done | eation during most of work d) | ing | 16b. Kind of Business/I | ndustry |
| 2121 | within sne. than ' | ldm | Elementary/Secondary (0-12) | ollege (1-4or 5+) | | ice Desig | | | U.S. Gove | ernment |
| 9 | filed Hygie | ပိ | 17. Father's Name (First, Middle, Last) | | | Tee Deal | | e (First, Middle, M | | |
| Maryland | ould be Mental arked o | To Be | Ernest Herbert Dahl | .er | | | Wilma | Marie Fo | ord | |
| ary | 2 should I and Men is marker aumatic | | 19a. Informant's Name/Relationship (Type. Pr | int) | | | | | City or Town, State, Z | |
| | 1 and 2 Health tem 27 i | | Linda L. Dahler / Wif | e I 20h Pi | | | | | ry, Marylar | |
| altimore, | permit. Pages 1 Department of I Important: If Ite any injury or of | | 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furey Servic Licenses | ai from State | derick | sition (Name of matory or other place Cremato) | ry 16, 2 | ber 2006 | Frederick, | Maryland |
| Ba | perm Depa Impo any i | | 21. Signature of Furiers Service Censes | × | 8 | E. Ridge | ville Blv | auffer Fi d. Mt. | uneral Home Airy, Mary | land 21771 |
| š | Physician /Medical Examiner | | | s that caused the death se on each line. Due to (or as a consequ | Do not en | | ng, such as cardiac | | | Approximate Interval Between Onset and Death |
| | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury | Due to (or as a consequ | ence of): | | | | | |
| | ecuted ind transi | Examiner | that initiated events C | D | | | | | | |
| 68760, | ficate be executed physician and s the burial-transit | ia E | ,000,000 | Due to (or as a consequ | erice oi). | | | | 1 | |
| | ificate g phys as the | edical | 0 | | | | | | | |
| P.O. Box | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/M | in the past 12 months? | yes, outcome pf pregnal □Live birth 2 □ Fetal □Pregnant at time of de □Unknown | death 3[| □Ectopic pregnanc □ Other (specify) _ | у | | 23d. Date of deli Month | very Day Year |
| | s that ned by | by Ph | Part II. Other significant conditions contribut | ing to death but not resu | Iting in the u | nderlying cause giv | en in Part I. | 23e. Did tob | pacco use contribute to | the cause of death? |
| ğ | equire en sig ould b | ted b | - Metastalic | Cular C | anc | 11 | | 1 ☐ Ye | es 2. No 3. Pr | obabiy 4 Unknown |
| Vital Records, | The law nate has be page 2 shi | Completed | | - | | | | 24a. Was ar autops perform 1∐ Yes 2 | y prior to o death? | topsy findings available ompletion of cause of 2 ☐ No |
| | sician certifi rector | Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospit | al: ↑□npatient 2□I | ER/Outpatie | nt 3 DOA Oth | or: | th (Check only one | | *** |
| ō | Phy: | ٦: ا | 27. Manner of Death 28 | a. Date of Injury | 28b. Time o | | | 28d. Describe ho | ence 6 □Other (Spec ow injury occurred | <i>ary)</i> |
| ion | inding ath. r: Afte ie fune | atior | 1 | (Month, Day Year) | Injury | | rk? Yes 2□No | | | |
| Division or | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined 28 | e. Place of injury - At ho building, etc. (Specify | me, farm, st | reet, factory, office | | 28f. Location (Str City or Town | reet and Number or Ru n, State) | ral Route Number, |
| | the Hospi in 24 hou the Funer ipletely fill | Medical | | | | nvestigation, in my | opinion, death occur | rred at the time, da | ate and place, and due | to the cause(s) |
| | With To | 2 | 29b. Signature and title of certifier. | on un | | 29c. Licens | 22101 | 25 | 9d. Date signed (Monti | 3,2006 |
| | 8 | | 30. Name and address of person who completed the state of | JUL W 14 | 175 | Print) | in fr | devel | pel 2 | 1702 |
| | Sta Regist | | 31. Date filed (Month, Dayl Year) NOV 1 6 20 | 32. Registry's Signa | | Spelle | | | V | |

State

Registrar

100 E

mD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hamle

0 9 2006

steven

NOV (

31. Date filed (Month,

29c. License number

00060225

Carroll St.

November

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar #10g per FH/wichd/11-9-06/dIGertificate of Death Reg. No. Amend item 7-2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:25 PM **Physician** upree arvin Cla 06 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisbur Wicomico whe If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1MM 2□F Yrs. 415-34-6648 76 /3/1930 Director Texas Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County •how r than "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Wicomico Hebron Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21830 120 Chapel Branch Drive USA 21830 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status be filed within 72 hours after de tal Hygiene. d other than "natural", or Item Black, White, etc. 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Office equipment Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: if item 27 is marked other ti jury or othar traumatic event, ID 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Delphia Mae Simpson Marvin Dupree 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Chapel Branch Dr., Hebron, MD 21830 Dorotha Jean Dupree/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: if any injury or once. 11/8/06 4 □Donation 5 □ Other (Specify) Salisbury Crematory Salisbury, MD ature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP gompoo Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Immediate Cause (Final disease or condition resulting in death) ærkinson's **Physician** /Medical Due to (or as a consequence of): Examiner eventia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performsy certificate 2∏ No 1 ☐ Yes 20 1 Yes r: After this certifica e funeral director, f 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient ဥ 1 TYes 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification; T Natural 2 ☐ Accident 5 Pending investigation м 1 ☐ Yes 2 ☐ No Director: npletely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sold Box 1733 Just1 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

NOV

0 9 2006

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 37890 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's N ame (First, Middle, Last) Month Year **Physician** 2006 8:42 A M November 13 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 17159 Sprecher Road Washington Boonsboro Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 🗙 F Yrs. July 5. Virginia Director 212-03-9004 90 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 le marked other than "naturel", or iteme 23s or 28s-f show other treumatic event, the Medical Examinar must be notified at 1 Yes 2XXVo Directo Boonsboro Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21713 USA 17159 Sprecher Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XXNo If Yes, Give Year or Dates: Specify: Specify: White 3

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NDT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) marked other than 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ John James Haley Elizabeth Pearl Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth E. Smedley - Daughter 17159 Sprecher Road Boonsboro, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any injury or ot once. remation 3 Removal from State Smithsburg Crematory Nov.14,2006 Smithsburg, Maryland 4 ☐ Dopetion 5/☐ Other (Specify) Osbonned Fourser allinHome, P.A. 21. Sign ture of Funeral Se 425 S. Conococheague St. Williamsport, Maryland Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw MONTHS HEAGI Immediate Cause (Final CONGESTIVE **Physician** disease or condition resulting in death) /Medical Examiner RI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine RENA physicien and s the burial-transit (or as a consequence of): O. Box 68760, Completed by Physician/Medical as ettending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has b irector, page 2 s autopsy performed? Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 2 No 1 🗌 Yes 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 EMatural 1 Tes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Confying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Indedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signa N 0022043 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGEKSTOWN. MS CAMMUS WH-5 31. Date filed (Month, Day, Year) 32. Registrar's Sign ture State 4 Registrar

Please Type or Print in Black Indelible Ink Katherine Johnson Elbert State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 7, 2006 Medical Examiner 2141 hrs Katherine Johnson Elbert 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Montgomery Suburban Hospital Bethesda 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** Foreign New Jersey Director Months Days Hours Mir 85 Feb. 24 1921 137-22-5678 1 M 2 X F Usual Residence of Decedent À 10a. State Oc. City, Town or Location 10d. Inside City Limits Silver Spring Md. Montgomery or 28a-f show 1 Yes 2 X No Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

"If item 27 is marked other than "natural", or item "natural" or item "natural". Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 15301 Wallbrook Court, #3-D United States Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 White etc. Married 2 × No Yes White Yes 2 No specify: 3 X Widowed f Yes. Give Year Divorced 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 3 Nursing Medical Hospital 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Alice Ferdinand Johnson Horner Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5187 Perry Road, Mount Airy, Maryland 21771 Charles B. Edwards / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State timore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State permit Pages Department of Important: I 11/13/06 Sandy Spring, Md. Friends Cemetery Donation 5 Other Specify: 0 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Muriel H. Barber Funeral Home 00470 Box 5038, Laytonsville, Md. 20882 Physician Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical signed by the attending physician a be detached for use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Year Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 ✓ No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ģ Yes 2 ✓ No 3 Probably 4 Unknown Completed s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 No ✓ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death
To the Funeral Director: After this certificompletely filled in by the funeral director; 25. Was case referred to medical 26 Place of Death (Check only one) Division of Vital Be Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other 1 🗸 Yes 28a. Date of Injury (Month, Day Year) Nov 7, 2006 27. Manner of Death 28b Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: Pedestrian struck by auto Natural 1724 hrs 5 Pending Yes 2 ✔ No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 1724 South Leisure Boulevard, Silver Spring, MD (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started, Medical (Check only one) 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME November 9, 2006 0 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registra DHMH 17 Rev 1/2001

OCME 2006

State

31. Date filed (Month)

2006

| | | | T = For State Registrar | State of Marylar | | | | lealth ar Death | nd Me | _ | giene Reg. Ne. | 006 | 37892 |
|-----------------|--|----------------|---|---|------------------------------|-------------------------------------|--------------------|------------------------------------|--------------------------|-------------------------------------|--------------------------|--|--|
| | Physici /Medio | | 1. Decedents Name (First, Middle, Last) | R H- | EWA | | | | l l | Date of De Month Novemb | er 9 | , 2006 | 3. Time of Death 4:38 p M |
| | Examir | er | 4a. Facility Name (If not institution, give: Washington Advent 5. Social Security Number 6. Sex | ist Hospital | (ast hirthday) | Tako | oma I | Location of Park | | . Date of Bir | Me Me | Ontgome | ry |
| | Funeral Director | | | M 2□ F 66 | Yrs. | Months | Days | Hours | Min. | (Month, Da 5-29- | y, Year) | | hplace (State or Foreign buntry) hington, DC |
| | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Exercipations than Le ricillish at | ai Director | Maryland Prince G 100. Street and Number 5019 Odessa Road | eorges Co | ollege | Park 101. Zip | Code | | | | _ | zen of What Co | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No puntry? |
| -0036 | hours after dea nural, or items | ed by Funeral | 11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 15. Decedent's Edu | 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: | | f Yes, sped | cify Cuba 2X No | ispanic Origin, Mexican, Specify: | n? (Specif Puerto Ric | fy Yes or No can, etc.) |)- 1 | 4. Race - Ame Black, White | e, etc. hite |
| 21215-0036 | ad within 72 glene. er than "na | Completed | (Specify only highest grade | College (1-4or 5+) | (Give | kind of wo DO NOT u: | rk done d | durina most c | of working | | | | usiness |
| Maryland | 2 should be filed and and Mental Hygie is marked other raumatic event, It | To Be (| 17. Father's Name (First, Middle, Last) Alexander Hall Ew 19a. Informant's Name/Relationship (Ty | | 10h Marilia | | (0 | G1ady | ys Ha | | | | 77-0-4-1 |
| Baltimore, Mai | it. Page rtment c rtant: # njury or | | | Spouse 20b. Removal from State | 5019 Place of Dispo | Odess sition (Nar natory or o | a Ro | ead, Co | 011eg Dat | ge Parl | k, Ma 20c. Loc Ale | Town, State, 2 aryland cation - City or xandria | 20740 Town, State |
| Ba | Depa Impo any li | | 23a. Part1. Enter the disease, or compli | | anno4 | 739 B | alti | more A | Ave., | Hyat | tsvil | 1 Home 11e, MD | 20781 Approximate |
| 8760, | Physician and / Medical Examiner the private and the private the private the private the private that the pr | dical Examiner | shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conse | quence of): | me | a Ira a | teng | N | Tea | ese | | Interval Between Onset and Death |
| .O. Box 6 | death certifi e ettending id for use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 3c. If yes, outcome of pregr 1□Live birth 2□Fet 4□Pregnant at time of 9□Unknown | al death 3 | Ectopic pr | | | | | 2 | 3d. Date of del Month | ivery Day Year |
| S, D | sign d be | by | Part II. Other significant conditions cor | ntributing to death but not re | sulting in the u | nderlying c | ause give | en in Part I. | | | | | othe cause of death? |
| of Vital Record | The taw ate has b page 2 sl | Completed | | | | | | | _ | 24a. Was autor perio 1 Yes | | prior to death? | utopsy findings available completion of cause of |
| VII. | Physician: this certific ral director, | Be | 25. Was case referred to medical examiner? | Hospital: X | | | Othe | | | Check only o | | | |
| of | Phys this ral di | 2 | 1 Yes 2 2 No | 1 El Inpatient 2 | BR/Outpatien 28b. Time of | | | 4 🗀 INUIS | | d. Describe I | | Other (Spec | cify) |
| Division | tending death. tor: After the fune | ertification; | 1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At I building, etc. (Spec | Injury nome, farm, str | М | | Yes 2 □ No | 0 | | Street and | | ural Route Number, |
| Ö | Hospital or At 124 hours after 6 Funeral Directed bited in by | edical Ceri | 29a. Certifier 1 Certifying Phys | sician: To the best of my kn | owledge, death | occurred | at the tim | ne, date and | place, and | d due to the | cause(s) | and manner as | stated. |
| | To the h within 24 | Medi | 29b. Signature and time of certifier | and manner stated. | | | | number | | | 29d. Date | signed (Monti | |
| | 120/ | | 30. Name and address of person who constant Salim Aziz, MD 31. Date filed (Month, Day, Year) | ompleted cause of death (Ite 11119 Rockvi | lle Pik | | uite | 100, | Rock | ville. | MD | 20852-3 | 1143 |
| | St: Regist | ate | NOV 1 = 2006 | Z > A | And. | j | | | | | | | |

| | | | State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 0 0 6 3 7 8 9 3 |
|----------------|--|---------------------|--|
| | - X | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death |
| П | Physicia | | Otelia Ruth Ennis November 10, 2006 23:53 P ^M |
| | /Medic Examin | | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death |
| | | | Prince George's Community Hospital Cheverly Prince George's |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 1 Year 1 Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 M 2 1 M 2 1 M 2 1 M 2 1 M 2 M 1 M 1 M |
| | Director | | 578-32-8093 94 |
| | and wo | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits |
| | Maryi f sho | ŏ | District of Columbia Washington 1∑Yes 2□No |
| | the | rec | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? |
| | h with | D | 4244 Marne Place, NE 20019 United States |
| | deal | ner | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White_etc. |
| 9 | filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Iteme 23a or 28e-f show ent, the Medical Examiner must be notified at | by Funeral Director | 1 Never Married 2 Married 1 Yes 2 M No 1 Yes 2 M No Specific Secretary |
| 21215-0036 | hours | q p | 3 M Wildowed 4 Divorced Year or Dates: American |
| <u>.</u> | in 72 | Completed | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry |
| 7 | iene. | E O | Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Statistician Government |
| פַ | e filec I Hyg othe | Be C | 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) |
| <u>la</u> | uld be Mental irked c | To B | James-Claude Smith Julia Monroe |
| Maryland | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28e-1 show any Injury or other traumatic event, the Madical Examinar must be notified at once. | | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Ennis - Daughter 4244 Marne Place, NE Washington, DC 20019 |
| | tem 27 | | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State |
| 30 | Pages nent of int: If it iry or o | | 1 Surial 2 Cremation 3 Removal from State 4 Ponation 5 Other (Specify) Harmony Mem. Park Nov. 18, 2006 Landover, Maryland |
| Baltimore, | permit. I Departm Importal sny Injui | | 21. Sign ture of Funeral Service Linesed 22. Name and Address of Facility Stewart Funeral Home, Inc. |
| Ö | Departing Supply It Supply | 0 | 4001 Benning Road, NE Washington, DC 20019 |
| | | | 23a. Parf. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition |
| | /Medical Examiner | | resulting in death) Due to (or as a consequence of) |
| | Lxammer | _ | Sequentially list conditions, if any leading to immediate Due to (or as a consequence of): Due to (or as a consequence of): |
| | nsit | nine | if any, leading to immediate cause. Enter underlying Cause (Disease or injury |
| | al-trai | Examiner | that initiated events resulting in death) Last C. Due to (or as a consequence of): |
| 8760, | ficate be executed physicien and s the burial-transit | dical | d |
| 68 | tificat ng phy as th | 0 | |
| ŏ | th cer tendir r use | an/N | IF FEMALE: 23b. Was decedent pregnant 1 |
| P.O. Box | Attending Physicien: The law requires that the death certificate be executed refeath. refath. refath setter: After this certificate hes been signed by the attending physicien and setter. After this certificate hes been signed by the funeral director, page 2 should be detached for use as the burial-transit | by Physician/M | in the past 12 months? 1 |
| o. | that the ed by detac | / Ph | Part II. Other significant conditions contributing to death but not/resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |
| Vital Records, | puires n sign ald be | q p | atrial perellate 1 Yes 2 No 3 Probably 4 Munknown |
| 00 | s been si should | jet | decutatur 24a. Was an autopsy findings available prior to completion of cause of |
| Re | The la | Completed | autopsy prior to completion of cause of performed? death? 1 □ Yes 2 ⋈ No 1 □ Yes 2 ⋈ No |
| ta | an: rtifice tor, p | O | 25. Was case referred to medical 26. Place of Death (Check only one) |
| > | nysic lis ce direc | To B | examiner? 1 Yes 2 No |
| 0 | ng Ph fter th ineral | :uo | 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 2b. Time of Injury 2b. Ti |
| Sio | eath. or: A the fu | catic | 2 Accident Investigation M 1 Yes 2 No |
| Division of | after d Direct Direct | Certification: | 3 Suicide 4 Homicide 6 Could not be determined 289. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 286. Location (Street and Number or Rural Route Number, City or Town, State) |
| | To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2 | | 29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
| | thin 2 the orther | Medical | one) and manner stated. 29b. Signature and fille of certifier 29c. License number 29d. Date signed (Mogth, Day, Year) |
| | F 3 F 8 | | All min |
| 1 | 1(4) | | 30. Name and ad less of person who completed cause of death (Item 23a) (Type, Print) |
| 1 | | | |
| | Sta Registr | | 1) James Alcras Prince George Appled 300/ Hospital Drive 31. Date filed (Month, Day, Year) NOV 1 5 2006 Seed S. Speck |

| | | | 1 = For State Registrar | State of Ivia | | | rtificate of | | | | Reg. No | | 27001 |
|---|---|----------------|---|---|---|-------------------------------|--|------------------------|---------------------------------|---|----------------------------|---|--|
| Ø5 | Physici | an | Decedent's Name (First, Middle, La. John Huck | | Ellio | !- !- | | | 2 | 2. Date of Dea Month | ath De | | 3. Time of Death |
| 1 to 1 to 1 to 1 to 1 to 1 to 1 to 1 to | /Medic | | 4a. Facility Name (If not institution, giv. | | E1110 | LL | 4b. City, Town, o | r Location | n of Death | | 40 | 2006 County of Dea | 144/1 ^N |
| 13 | - LXuiiiii | | PENINSULA REGIONAL | Medron C | ENTO | | | X15B | | | | | nico |
| \$2 | Funeral Director | | 215-20-1729 | res to a minute of the second | (In yrs. lasi 80 | birthday) Yrs. | If Under 1 Year Months Days | If Unde Hours | er 24 Hrs. 8 Min. | 3. Date of Birt. (Month, Day 5/6/19 | h V. Year, 26 | 9. Bii | rthplace (State or Foreign ountry) aryland |
| | land ow | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, T | own or Lo | ocation | | | | | | 10d. Inside City Limits |
| | e Mary a-f sh tified | ctor | Maryland Wicomid | 20 | Heb | ron | | | | | | | 1 XYes 2 No |
| | th with th | al Director | 10e. Street and Number 8842 Olde Floris | st Lane | | | 10f. Zip Code 2183 | 0 | | | _ | tizen of What C SA | ountry? |
| 036 | be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced | 12. Was Decedent E Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: | | | Was Decedent of HII Yes, specify Cuba 1 ☐ Yes 2 X No | | | ify Yes or No- ican, etc.) | | 14. Race - Am Black, Whi Specify: | |
| 21215-0036 | "natul "natul edical | Completed | 15. Decedent's En (Specify only highest gra | ducation ade completed) | 1 | 6a. Dece | dent's Usual Occup kind of work done DO NOT use retired | ation during m | ost of working | , | | afood/pi | , |
| 212 | withir jiene. | omp | Elementary/Secondary (0-12) | College (1-4or 5+ |) | | er/operate | | | | | siness | coduce |
| ğ | 0 = 0 0 | To Be C | 17. Father's Name (First, Middle, Last, |) | • | | | | | First, Middle, | | , | |
| Maryland | should be filed and Mental Hygi s marked other umatic event, t | ပ္ | Raymond Elliott 19a. Informant's Name/Relationship (| Time Brint | | 10h Maili | ng Address (Street | | | | | Hughes | 7:- Coda |
| , Ma | and 2 si ealth an n 27 is r ner traur | | Georgia Rhodes/da | | | 280 | 081 Nanti | | Rd., | Salisb | ury | , MD 218 | 301 |
| Baltimore, | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es <u>once.</u> | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specil | (y) | cem | etery, crei ela M etery | osition (Name of matory or other place lemorial | | 11/8 ₂ | /06 | Maı | | orings, MD |
| Bai | permit Depar Impor any in | - | 21 Signature of Funeral Service Licer | 10 | CFS | P 2 | Holloway 501 Snow | Fund Fund Hil | eral He | ome Pro | ofes | ssional | Association |
| | 1 | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused to one cause on each line | he death. | Do not ent | | | | | | , 115 21 | Approximate Interval Between |
| g in | Physician | | Immediate Cause (Final disease or condition resulting in death) | a CONGE | STI | JE | HEAR | | AILU | | | | Onset and Death 30 DAYJ |
| <i>j.</i> | /Medical Examiner | | resulting in death) | Due to (or as a | IC CARDIOMYOPATHY | | | | | | | | 2 YEARS |
| Wy | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a | consequer | ice of): | | | | | | | |
| | ecutec and -transi | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | C | c. MYO CARDIAL IN FARCTIONS Due to (or as a consequence of): | | | | | | | | 24 EARS |
| 68760, | icate be executed physician and s the burial-transit | | | consequer | ice oi). | | | | | | | | |
| | rtificate ng phy as the | Medical | IF FEMALE: | u | | | | | | | | | |
| P.O. Box | The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit | Physician// | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown | Fetal de | eath 3[| Ectopic pregnancy Other (specify) | у | | | | 23d. Date of de Month | olivery Day Year |
| | w requires that the de been signed by the should be detached | by Ph | Part II. Other significant conditions | | not resultir | ng in the u | nderlying cause giv | en in Par | t I. | 23e. Did to | bacco | use contribute t | o the cause of death? |
| oras | require sen sig rould b | | CHRONIC | , | ALELI | - | 215-21 | · – | <u> </u> | 1 🗆 Y | es 2 | No 3□ | robably 4 □Unknown |
| Vital Records, | | Completed | CHRONIC | - 1710 | NEY | _ | DISERS |) E | | 24a. Was autop perfor 1 Yes | | prior to death? | |
| V Ita | certific rector, | Be | 25. Was case referred to medical examiner? | Hospital: | | | ot 3 DOA Oth | Or' | | Check only o | | | |
| | g Phys er this eral dir | J: To | 1 ☐ Yes 2 ☐ Mo 27. Manner of Death | 28a. Date of Injury | 28 | Bb. Time o | IL OLI DOX | 4 🗆 1 | | e 5 Resid | | 6 □Other (Spenify occurred | ecify) |
| i N | tending Fleath. tor: After the funer | atior | 1 √ Natural 5 ☐ Pending 2 ☐ Accident investigation | | Year) | Injury | | Yes 2[| □No | | | | |
| Division or | al or Atter after de 1 Directo d in by ti | Certification: | 3 Suicide 6 Could not b 4 Homicide determined | | y - At home (Specify) | e, farm, str | reet, factory, office | | 28 | f, Location (S City or Tow | Street ai | nd Number or Fi e) | dural Route Number, |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director. | edical C | 29a. Certifier 1 ☐ Certifying Pr (Check only one) 2 ☐ Medical Exam | nysîcian: To the best o' niner: On the basis of and manner stat | examination | edge, deat and/or in | h occurred at the til vestigation, in my o | me, date opinion, d | and place, ar leath occurred | nd due to the od at the time, | cause(s date an | s) and manner and place, and du | s stated. e to the cause(s) |
| 1 | To th within | Me | 29b. Signature and title of certifier | lac | lu | 2, | 29c. Licens | e numbe | 962 | | 29d. Da | ate signed (Mon | th, Day, Year) R 04, 2006 |
| (| SOLE | | 30. Name and address of person who M : 5 H / R A 2 1 , P | | | | | | | | | | |
| | Sta | | 31. Date filed (Month, Day, Year) | 32. Registra | 's Signatur | е | | | | | - | | |
| | Registr | ar | NOV 0 9 | ZUUB Market | a t | 2 1 | north ! | _ | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Gladys 0. Fow1kes November 6.50 FM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Prince George's Lanham Birthplace (State or Foreign Country) 5. Social Security Number Age 74 (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐XF Severn, MD Director 212-34-7618 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10d. Inside City Limits 1 X Yes 2 □ No Director Prince George's Landover 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 20785 United States 7203 E. Forrest Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Otelia Miles Mahlon Queen 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Roland J. Fowlkes - Husband 7230 E. Forrest Road Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 11/18/2006 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee Lupy 3401 Bladensburg Road Brentwood, MD 20722 23a. Part1. Enter the rise are, or complications that caused the death. Do not enter the mode of dying, such as carr lac or respiratory arrest shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 XNo 9 Unknown Part II. Other significant condition contributing to death but no esulting in the inderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform certificate 2 X No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death Certification: 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 16 Natural 2 ☐ Accident 5 Pending investigation 1 🔲 Yes 2 🗌 No within 24 hours arrei ueau...

To the Funeral Director: 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examines: On the basis of examination and/of investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29c. License number

31. Date filed (Month, Day, State Registrar

me and address of person who completed cause of 15 th (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month Physician Gwendolyn Theresa November 8:48 A 11, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince Georges Clinton, Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan 28, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 💥 F 1948 Yrs Washington, DC Director 579-66-9456 58 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ul Hygiene. other than "natural", or Iteme 23a or 28a-f ehov vent, the Medical Exeminer must be notified at Yes 2 □ No Director Maryland Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7910 Mayapple Court 20735 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No **Black** Specify: ģ 3

Widowed 4

□ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ? John Bridges Elizabeth Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7910 Mayapple Court, Clinton, MD f Health item 27 l Mark Ford / Son 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery | Nov 17, 2006 Bladensburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Doense ²²Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20747 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear vailure. List only one cause on each line. Approximate Interval Between Ogset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign 1 be 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s autopsy 2L No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Illed in by 4 T Homicide hours after within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) OLD 12070 32. Registrar's Signature State Registrar

| | | | | i icase i | State of Ma | | | | | | | • | |
|-------------|---|----------------|--|--|---|------------------------------|--------------------------------|--|--|---|----------------------|---------------------------------|---|
| | | | 1 - For State Registrar | | Otate of Me | in y laina / | - | tificate of | | • | _ | 2006 | 37897 |
| | 0 | | Decedent's Name (| First, Middle, Last |) | | | | | 2. Date of De | ath | | 3. Time of Death |
| | Physici /Medio | | Howard | I. | Foreaker, | Jr. | | | | NOVEMB | ER Da | Year 200 | 6 1659 M |
| | Examir | | 4a. Facility Name (If n | ot institution, give | street and number) | | | 4b. City, Town, o | r Location of De | ath | 4c | . County of Dea | |
| | | | Union Ho | | | | 11.45 1 3 | Elkton | Killedes 04 U | | | ecil | |
| | Funeral Director | | 5. Social Security Num 215-32-2 | | x X_M 2□F 7. Age | i (In yrs. last i 73 | Yrs. | If Under 1 Year Months Days | If Under 24 H Hours Mi | in. (Month, Da | ay, Year) | | hplace (State or Foreign |
| | | | Usual Residence of D | | | | | | | 07/07/ | /193. | 3 Mai | ryland |
| | arylan show | ڀ | | 0b. County | | 10c. City, To | | | | | | | 10d. Inside City Limits |
| | he M | Director | MD 10e. Street and Numb | Cecil | | Nort | th Ea | | | | | | 1 □ Yes 2 XNo |
| | with 1 | ă | 2369 Turl | | t. Road | | | 10f. Zip Code 21901 | | | 10g. Cit | izen of What Co S∆ | ountry? |
| | be filed within 72 hours after death with the Maryland Hygiene. d other than "natural; or items 23e or 28e-f show event, the Madical Examir er must be mailfad an event, the Madical Examir er must be mailfad an | Funeral | 11. Marital Status | | 12. Was Decedent B | Ever in U.S. | 13. V | | lispanic Origin? | (Specify Yes or No erto Rican, etc.) | | 14. Race - Ame | nican Indian, |
| ထွ | after or the | | 1 Never Married | 2 X Married | Armed Forces? 1 XYes 2 □ N If Yes, Give 1 9 Year or Dates: | lo F2 405 | _ 1 | Yes, specify Cubi | an, Mexican, Pui Specify: | erto Hican, etc.) | | Black, Whit | |
| 90 | hours ural', | d by | 3 Widowed 4 | | | | | | | | | | White |
| 7 | n 72 "nat | Completed | (Specify | Decedent's Edu only highest grad | lcation le co <i>mpleted)</i> | 16 | Sa. Deced (Give I life D | ent's Usual Occup kind of work done OO NOT use retired | ation <i>duri</i> ng most of w | vorking | 16b. K Cai | ind of Business cpenters | Industry 5 Union |
| 212 | d with giene. r thar | mo | Elementary/Second | ary (0-12) | College (1-4or 5 | +) | | working | -7 | | | cal 626 | |
| פ | be filed that Hygie od other tevant, It | Bec | 17. Father's Name (Fig. | | · | | | | | ame (First, Middle, | | | |
| <u>yla</u> | | 10 | Howard I | | | | | | Martha | Jane Rey | molo | ds | |
| <u>a</u> | 12 sh hand rism raum | | 19a. Informant's Name | | | | | | | Rural Route Numbe ad, North | | | |
| | s 1 and 2 should f Health and Mer itam 27 is marke other traumetic | . 3 | 20a. Method of Dispos | | Saker Wi | Tool Di | | | | | | | |
| Baltimore, | permit. Pages 1 Department of H Important: If ita any injury or ott once. | | | Cremation 3 🗆 F | Removal from State | Nort | tery, crem n Eas | atory or other place t Method | ist 11 | /18/2006 | Nor | th East | MD |
| | mit. F portar portar / injur | | 21. Signature of Fund | | m/ / | 1 | Cemet | ery Name and Addre | ss of Facility | amily Fur | | 1 77 | 1110 |
| ñ | P P P P P | | Celh | The | Me- | | 63 | 5 Church | mans Rd | Mewark, | DE 1 | 19702 | |
| | | | 23a. Part1. Enter the shock, or heart f. | disease, or compl ailure. List only or | ications that caused ne cause on each lin | the death. De | o not ente | r the mode of dyin | g, such as cardi | ac or respiratory a | rrest, | | Approximate Interval Between |
| Ŧ | Trysician | i i | Immediate Cause (Fir | nal / | SEPSIS | <u> </u> | | | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | | Due to (or as a | | | | | | | | |
| | | er | Sequentially list condi | odiato | Due to (or as a | | e of): | ché (| Couns | ¥ | | | |
| | uted d ansit | Examin | cause. Enter Underly Cause (Disease or inju- that initiated events | ing ury | CIRRI | 21704 | | | | | | | |
| Ď | ate be executed hysician and he burial-transit | Exa | resulting in death) Las | st T | Due to (or as a | consequenc | e of): | | | | | | |
| 8/60, | ate by | dical | | | 5ND | STAG | E | RENAL | FAN | MLE | | | |
| RO X | leath certificate attending phys I for use as the | Physician/Med | IF FEMALE: | 2 | 3c. If yes, outcome of | of pregnancy | | | | | | | |
| Š R O | | clan | 23b. Was decedent print the past 12 mo | onths? | 1☐Live birth 2 4☐Pregnant at t | 2 🗌 Fetal dea | | Ectopic pregnancy Other (specify) | | | 1 | 23d. Date of deli Month | very Day Year |
| j ; | that the death | hys | 9 Unknown | 10 | 9□ Unknown | | | | | | | | |
| , S | 56 50 | by P | Part II. Other significa | nt conditions cor | ntributing to death bu | t not resulting | in the un | derlying cause giv | en in Part I. | 23e. Did to | obacco u | se contribute to | the cause of death? |
| ord Ord | w require been si should t | | | | | | | | | 1 🗆 1 | /es 2 | No 3□Pr | bably 4 \(\begin{array}{c}\text{Unknown}\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ |
| ပ္ | ≥ 0 ti | ompleted | | | | | | | | 24a. Was autop | SV | prior to d | topsy findings available completion of cause of |
| | page In | 0 | | | | | | | | | rmed? No | death? | 2XNo |
| VITAI | rnysicien: this certific ral director, | o Be | 25. Was case referred examiner? | 1 | lospital: Inpatier | nt 2 ER/C | Sutmationt | 3 DOA Oth | ne. | eath (Check only o | | | |
| 0 | ding Pnys h. After this funeral di | - | 27. Manner of Leath | | 28a. ate of Injury | / 28b | Time of | 28c. Injun | / at | Home 5 Resid | | | erry) |
| VISION | andin ath. or: Aft | atio | 2 Accident | 5 Pending investigation | (Month, Day | rear) | Injury | M 1 | Yes 2□No | | | | |
| | of or Attending to after death. I Diractor: After din by the funer. | Certification: | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not be determined | 28e. Place of Inju building, etc. | ry - At home, . (Specify) | farm, stre | et, factory, office | | 28f. Location (S City or Tox | | | ral Route Number, |
| ב ק | ours al | | 29a. Certifier | Cartifying Bhy | Sigion. To the horse | f t t d- | | | | <u>V </u> | | | |
| - | To the Hospitel of Attention within 24 hours after deat To the Funeral Director: completely filled in by the | edical | (Check only one) | Medical Examin | sician: To the best oner: On the basis of and manner state | examination a | ge, death and/or inve | occurred at the tine estigation, in my o | ne, date and plac pinion, death occ | ce, and due to the c curred at the time, o | cause(s) date and | and manner as place, and due | stated. to the cause(s) |
| | vithin To the | Me | 29b. Signature and title | e of certifier | | | | 29c. License | e number | | 29d. Dat | e signed (Month | , Day, Year) |
| | | | A HAVE | | | | | Do | 006 46 | ,70 | JOVE | moer 1 | 3. 2006 |
| ıſ | HIVA | | 30. Name and address | of person who co | empleted cause of de | ath (Item 23a |) (Type, P | | | - | | | |
| 10 | | | MONIQUE 31. Date filed (Month, | Day Year) | MUNAMY 32 Banistra | Signature | 18 | 6 BOL | ST. | ELKINIA | i, M | 0 21 | 921 |
| | Sta Registr | | | 1 6 2006 | 32. Registra | K X | Joses | W . | | | | | |

State Registrar

DHMH 17 Rev 1/2001

3

31. Date filed (Month, Day, Year)

nth, Day, Year) 32 Regis

Cause of death (Item 23a) (Type, Print)

44996

Lappans Rd Boonsbow MD 21713

| | | • | For 1 = State Registrar | State | of Marylar | | ment of I | | Mental Hyg | iene g. No. 2001 | 5 37899 |
|-------------------|---|-----------------|--|-------------------------------|-------------------------------------|------------------------|------------------------------------|--|--|-------------------------------|--|
| | | | 1. Decedent's Name (First, Midd | fle, Last) | | | | - | 2. Date of Deal Month | h Day Yea | 3. Time of Death |
| | Physici /Medic | | Richard David F | reed | | | | | November | | |
| ř | Examin | | 4a. Facility Neme (If not institution | on, give street and i | number) | 4 | b. City, Town, | or Location of Dea | th | 4c. County of De | ath |
| | | | Glade Valley Nu | | | | alkersv | | | Frederic | |
| | Funeral | | 5. Social Security Number 217-32-7418 | 6. Sex 1 ☎ M 2 ☐ F | 7. Age (In yrs. | N. N | fonths Days | If Under 24 Hr Hours Mir | . (Month, Day, | Year) 9. B | irthplace (State or Foreign Country) |
| | Director | | Usual Residence of Decedent | <u> </u> | 70 |) | | | 0ct. 30 | , 1936 Ma | ryland |
| | yland | | 10a. State 10b. Count | у | 10c. Ci | ty, Town or Locat | ion | | | | 10d. Inside City Limits |
| | a-f el | to | Maryland Freder | ick | Fred | erick | | | | | 1 X Yes 2 No |
| | or 28 | Oire | 10e. Street and Number | | | | 10f. Zip Code | | 1 | 0g. Citizen of What | Country? |
| | ath w | rai | 103 Catoctin Av | | | | 21701 | | | SA | |
| | er de | Funeral Directo | 11. Marital Status | Armed | ecedent Ever in U Forces? | J.S. 13. Wa | s Decedent of I es, specify Cub | Hispanic Origin? (an, Mexican, Pue | Specify Yes or No- rto Rican, etc.) | 14. Race - An Black, Wi | nerican Indian, nite, etc. |
| 36 | rs aft | by F | 1 ☐ Never Married 2 📉 Ma 3 ☐ Widowed 4 ☐ Divorce | If Voc I | s 2∭No Give rDates: | 1□ | Yes 2∭ No | Specify: | | Specify: | 4 |
| 21215-0036 | within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f ehow the Madigal Examiner must be notified at | led | 15. Decede | nt's Education | | 16a. Deceden | t's Usual Occu | pation | | 16b. Kind of Busines | :ite :s/Industry |
| 215 | hin 7. | pie | (Specify only high Elementary/Secondary (0-12) | est grade complete College | d) e (1-4or 5+) | (Give kin life. DO | d of work done NOT use retire | during most of word) | orking | | |
| 2 | filed wit Hygiens Sther the | Completed | 12 | | | Pot Li | ne / La | borer | | luminum P | roduction |
| p | be file | Be (| 17. Father's Name (First, Middle | , Last) | | | | 18. Mother's Na | me (First, Middle, I | Maiden Sumame) | |
| Maryland | 2 should be filed within 72 hours atler death with the Marylan and Mental Hygiene. Is marked other then 'natural', or items 23s or 28s-f show atmatic event, the Madical Examinar must be notified at | ၉ (| George Franklin | | r. | | | | Mary Paz | | |
| Mar | 12 sh h and h and 7 is m | | 19a. Informant's Name/Relation | | | | | | | City or Town, State | |
| | permit. Pages 1 and 2 should Department of Health and Men Important: It Item 27 is marke ery injury or other traumatic. | 1 | Shirley Ann Wil 20a, Method of Disposition | ls Freed, | | _ 103 Cat | | Avenue, | | Mary 1an 20c. Location - City | |
| altimore, | Pages nent of I ant: It its ury or o | | 1 X Burial 2 ☐ Cremation | | m State | cemetery, cremat | ory or other pla | 1 | | · | |
| ₽ | artme artme ortani injury | | 4 Donation 5 Other (| | CIU | | | | | rederick, | Maryland Funeral Home |
| Ba | Depring eny | | - Kyauhi | 5, | мос | | | | | ederick, | |
| | | | 23a. Part 1. Enter the disease, of shock, or heart failure. Lis | or complications tha | | | | | | | Approximate |
| H | Physician | | Immediate Cause (Final | | | | | | | | Interval Between Onset and Death |
| | /Medical | | disease or condition resulting in death) | | eroscler to (or as a consec | | dlovas | cular Dis | sease | | Years |
| | Examiner | | 0 | , Dia | betes Me | 11itus | | | | | Years |
| _ | n = | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due 1 | to (or as a consec | quence of): | | | | | |
| 13 | ecute ind trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c | | | | | | | |
| 760, | te be executed ysicien and e burial-transit | | resulting in south) East | Due | to (or as a consec | quence or): | | | | | |
| 687 | # 7 B | diçai | | d | | | | | | | |
| | death certifical e attending phi id for use as th | Physician/Med | IF FEMALE: | 23c. If yes, | outcome of pregn | ancy | | | | 23d. Date of d | Alman |
| .О. Вох | atten for u | clan | 23b. Was decedent pregnant in the past 12 months? | 1 Live | e birth 2 🗍 Feta | al death 3 □Ed | topic pregnand ther (specify) _ | :y | | Month Month | Day Year |
| o. | 0 0 9 | hysi | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□ Unl | known | | .,,,, | | | | |
| ď. | The law requires that the ste has been signed by the bage 2 should be detached. | by P | Part II. Other significant condit | ions contributing to | death but not res | sulting in the unde | rlying cause gr | ven in Part I. | 23e. Did tot | acco use contribute | to the cause of death? |
| ğ | w require been sig should b | | Renal Insuffic | iency | | | | | 1 □ Y€ | s 2½∏No 3⊟ | Probably 4 Unknown |
| Records, | e law re has be | piet | | | | | | | 24a. Was a | n 24b. Were | autopsy findings available o completion of cause of |
| Ě | Physician: The la r this certificate has ral director, page 2 | Completed | | | | | | | perform | ned? death' | es 2 No |
| Division of Vital | Physician: this certificatal director, p | Be (| 25. Was case referred to medic examiner? | | | | | | eath (Check only on | | |
| <u></u> | hysik this c | 2 | 1 ☐ Yes 2 📉 No | | □Inpatient 2□ | | 3 DOA | her: 4 📉 Nursing | | nce 6 Other (Sp | pecify) |
| Ĕ | ding F h. After funera | ion: | 27. Manner of Death 1 X Natural 5 ☐ Pend | 9 | te of Injury onth, Day Year) | 28b. Time of Injury | 28c. Inju | | 28d. Describe ho | w injury occurred | |
| S | or Attending after death. Director: After in by the fune | cat | 3 ☐ Suicide 6 ☐ Could | | ace of Injury - At h | Ome farm street | |]Yes 2□No | 28f Location (St | reat and Number or | Rural Route Number, |
| <u>></u> | | Certification; | 4 Homicide deter | mined 200. Pla | ilding, etc. (Speci | fy) | , lactory, onice | | City or Town | | Tal al Flooto Nambol, |
| | e Hoepital or 24 hours afte e Funerat Dir letely filled in l | a C | 29a. Certifier 1 X Certify | ing Physician: To | the best of my kno | owledge, death or | curred at the t | me, date and place | e, and due to the ca | ause(s) and manner | as stated. |
| | To the Hospital or within 24 hours after To the Funeral Dir completely filled in | edical | (Check only 2 Medical one) | i Examiner: On the | a basis of examina anner stated. | ation and/or inves | tigation, in my | opinion, death occ | curred at the time, da | ate and place, and d | ue to the cause(s) |
| | To the within 2 To the I complet | ž | 29b. Signature and title of certific | er A | | | 29c. Licen | se number | 2 | 9d. Date signed (Mo | nth, Day, Year) |
|) | | | M. | 15 | | | D2651 | 16 | No | ovember 21 | , 2006 |
| | 8 | | 30. Name and address of pars | Ano completed ca | ause of death (Ite | m 23a) (Type, Pri | The same of | 11 | | | Of the section of the |
| | | | Allen J. Gilson | | | | #204, | Frederic | ek, Maryla | and 21702 | |
| | Sta Registr | | | | . Registrar's Sign | | Me) | | | | |
| | | | PALLY 2. | | ALCOHOL: A | | | | | | |

| | | | 1 - State Registrar | State of Ma | aryla | • | artmen rtificat | | | | | Reg. No | 006 | 37900 |
|-------------|--|------------------|---|---|----------------------|---|--|------------------------------|---------------------------------|----------------------------|--|-----------------------|--|--|
| | Physici /Medi | | Decedent's Name (First, Middle, Last) | MARGIE | v. | FLICK | INGER | | | | 2. Date of Dea Month OVEMbe | | 200 ^Y 6 ^{ar} | 3. Time of Death 5:00 A M |
| | Examir | ner | 4a. Facility Name (If not institution, give str 2403 Trevanion I | Road | | | Tane | eytov | | | | | County of Dea | County |
| | Funeral Director | | 5. Social Security Number 213-14-2193 6. Sex | 7. Ag | e (In yr. | s. last birthday) 85 Yrs. | If Under Months | 1 Year Days | Hours | | B. Date of Birt (Month, Day ep. 3, | 192 | | thplace (State or Foreign ountry) yland |
| | the Maryland 28e-f ehow | tor | 10a. State 10b. County Maryland Carroll | County | | City, Town or Lo Taneyt | | | | | | | | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No |
| | th with the 23e or 28 | Funeral Director | 10e. Street and Number 2403 Trevanion Road | | | | 10f. Zip 21 | Code 787 | 1 | | | - | en of What C | • |
| 9800 | 72 hours after death with the Maryland naturel', or items 23e or 28e-f ehow deat Examiner must be notified at | by | 11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced | . Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If If Yes, Give Year or Dates: | | | Was Deced f Yes, spec | | spanic Origin, Mexican Specify: | gin? (Speci , Puerto Ri | ify Yes or No- can, etc.) | | 4. Race - Ame Black, Whit Specify: W | te, etc. |
| 21215-0036 | s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene it the firm 27 is marked other then "naturel", or flems 23e or 28e-f ehow other treumetic event, the Modical Examiner outside in cliffied at | Completed | 15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) | | i+) | | lent's Usua kind of wor DO NOT us P WOY | k done d e retired) | tion uring most | t of working | | | d of Business Lishing | Industry Company |
| Maryland | S should be file and Mental Hy is marked oth sumetic event | To Be (| 17. Father's Name (First, Middle, Last) Charles Cashman | | | | | | Jess | sie Ro | | | | |
| | ss 1 and 2 sh of Health and item 27 is m other treum | | 19a. Informant's Name/Relationship (Type Helen C. Halter / | | 100 | 444 | East | Balt | imore | e Stre | et Ta | neyt | | d. 21787 |
| Baltimore, | 0 0 | | 20a. Method of Disposition 1 | ^ | | Place of Dispo cemetery, cren inity L | uther | an C | em. | Nov. 2 | 25 | | eytown, | Town, State Maryland |
| Bal | permit. Pag Department Importent: b eny injury o | | 21. Signature of Funeral Service Licenses | unn | | 1 | Name and | st B | altim | ore S | treet | Tar | l Home Leytown | , Md. 21787 |
| | Physician /Medical | | 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) | cause on each lin | (| Failure | tota | ~ ~ ~ | | cardiac or r | espiratory arr | est, | | Approximate Interval Between Onset and Death |
| k | Examiner | - G | f | Due to (or as | | he mer. | s 0. | epan | ilvs | | | | | 730 |
| 8760, | ate be executed hysician and the burial-transit | dical Examiner | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as | | | | | | | | | | |
| .O. Box 68 | The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Tyes 2 No 9 Unknown | If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown | 2 Fel | tal death 3 | Ectopic pre Other (spe | egnancy ecify) | | | | 23 | 3d. Date of del Month | ivery Day Year |
| rds, P. | quires that n signed by | by | Part II. Other significant conditions contri AGG | buting to death bu | it not re | sulting in the un | derlying ca | use giver | n in Part I. | | | | | the cause of death? |
| | | Completed | H70 | | - | | | | <u> </u> | | 24a. Was a autops perform | | 24b. Were au prior to death? | stopsy findings available completion of cause of |
| ion of Vita | Attending Phyelcien: T r death. ector: Affer this certificat by the funeral director, ps | atlon; To Be | I Tes ZANO | pital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day | | ER/Outpatient 28b. Time of Injury | | Other Sc. Injury Work? | . 4 □ Nur: | sing Home | 5 Reside | ence 6 | □Other (Spec | cify) |
| É | i Sign | Certification: | 3 🗀 Suicide 6 🗀 Could not be 4 🗀 Homicide determined | 28e. Place of Inju building, etc | ry - At I . (Spec | nome, farm, stre ify) | et, factory, | office | | 28f | Location (St City or Town | reet and 1, State) | Number or Ru | ral Route Number, |
| | To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in | edicai | 29a. Certifier (Check only one) | : On the basis of | examin | ation and/or inv | estigation, | in my opi | nion, death | h occurred | at the time, di | ate and p | lace, and due | to the cause(s) |
|) | vith To 1 | Σ | 29b. Signature and title of certifier Alu duh | rsien | ~ | | 29c. | License M 3 | number | 260 | 21 | 9d. Date | signed (Month | n, Day, Year) |
| | 8 | | 30. Name and address of person who comp | pleted cause of de A d con 32. Jegistra | ath (Ite | m 23a) (Type, F | Print) Sem | 4/ | hD | 5 24 S | weshing | stan | 8/23/ | 4) |
| 4 | Sta Registr | | 31. Date filed (Month, Day, Year) | 32. egistra | r's Sign | B Go | 342 | | | | 4 | | , | |

| | | | State of Maryland / Department of Health and N 1- State Registrar Certificate of Death | | 21116 | 37901 |
|--------------------------------|--|-----------------|---|---|---|--|
| | _ | | 1. Decedent's Name (First, Middle, Last) | Reg. | No | 3. Time of Death |
| | Physici | | _ | | Day Year 12 2000 | |
| | /Medio Examin | | Frances Louise Grove 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death | 1000 | 4c. County of Deat | |
| П | LXdiiii | | Fahrney-Keedy Mursing Home Boonsboro | | | naton |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | 8. Date of Birth | 0.00 | hplace (State or Foreign |
| | Director | | 214-34-9558 104 Yrs. 104 | Feb. 13, | 1902 | Maryland |
| | and | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits |
| | Maryl f sho | Į. | Maryland Washington Boonsboro | | | 1 ☐ Yes 21 No |
| | 28e | Director | 10e. Street and Number 10f. Zip Code | 10g. | Citizen of What Co | untry? |
| | h with | | 8507 Mapleville Rd. 21713 | | 11' | SA |
| | deat | Funerai | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto | pecify Yes or No- | 14 Race - Ame Black, White | rican Indian, |
| 36 | or it | y Fu | 1) Never Married 2 Married 1 Yes 2000 | 7 (102), 5(5), | Specify: | e, etc. |
| Ö | hours turel' | Completed by | 3 Wloowed 4 Divorced Year or Dates: | 404 | | White |
| 15 | in 72 "ne" r | oiete | 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) | king | . Kind of Business/ | Industry |
| 72 | with liene. | mo | Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Librarian | | Med | ical |
| פ | be filed within 72 hours efter death with the Maryland ital Hygiene. d other then "neturel", or items 23a or 28e-f show event, I're Madical Exertirer must be natified at | Be C | | e (First, Middle, Maid | | rear |
| /lai | uld b Ments arked | ToE | Alva Dillon Grove Julia | Katherine | Mummu | |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then. Insturet, or items 23a or 28e-1 show entry injury or other treumetic event, It a Madical Examinat must be notified at once. | | 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Run</i> | ral Route Number, Ci | ty or Town, State, 2 | ^{Zip Code)} 21795 |
| <u>ک</u> ن | l and lealth im 27 ther to | | Wilson B. Waddy - Cousin 16505 Virginia Ave. (20a. Method of Disposition (Name of 1878) | | | Maryland |
| õ | tof H if ite or of | | 1 ☐ Burial XXCremation 3 ☐ Removal from State cemetery, crematory or other place) | | Location - City or | |
| Ħ | it. Partitude intent | | '4 Donation Gother (Specify) Smithsburg Crematory Nov. 1 21. Signature of Funeral Service Ligarises (22: Name and Address of Facility Hon | 13,2006 Sm | ithsburg | Maryland |
| Ba | permi Depa Impo eny ir | | 21. Signature of Furneral Service Lidersee GS 5000 me Address e Ferilly Hon 425 S. Conococheage | • | liamenne | 21795 |
| | 51.57 | | 23a. The Enter the issue as each or community attions that caused the death. Do not enter the mode of dving, such as cardiac is | | Trainsport | Approximate Interval Between |
| 8 8 | Physician | | shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition | | | Onset and Death |
| | /Medical | | disease or condition resulting in death) a. Coronary Artery) 19 cese Due to (or as a consequence of): | | | LUKUDEN |
| Н | Examiner | | Sequentially list conditions, b | | | |
| | sit ad | Examiner | fl any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause, (Disease or Injury | | | |
| _ | xecuti and II-tran | xan | that initiated events resulting in death) Last Due to (or as a consequence of): | | | |
| 8760, | icate be executed physician and s the burial-transit | dical E | | | | |
| 687 | ifficate g phy as the | edic | u | | | |
| Вох | eath certific attending p i for use as i | M/u | IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy | | 23d. Date of deli | very |
| | e deal | by Physician/Me | 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) | | Month | Day Year |
| P.O. | that the de led by the a detached I | Phy | 9 Li Unknown | OO. Didash. | | |
| Vital Records, | w requires that been signed be should be det | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacc | | the cause of death? |
| Ö | required | ompleted | Danestin | | | |
| Rec | has ge 2 s | ldm | Dane 1tia | 24a. Was an autopsy performed | prior to c | topsy findings available ompletion of cause of |
| a | icien: Th certificate rector, pag | e Co | 25. Was case referred to medical 26. Place of Death | 1 □ Yes 2 🚉 | | 2 No |
| > | ysicien: The I is certificate ha director, page | 0 B | examiner? Hospital: Other | h (Check only one) ome 5 ☐ Residence | 6 □Other (Sner | 10 |
| ס | g Phys ter this neral di | n: T | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at | 28d. Describe how in | | ary) |
| joi | endin aath. or: At | atio | 2 Accident investigation M 1 Yes 2 No | | | |
| Division of | r Att | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street City or Town, St | and Number or Ru ate) | ral Route Number, |
| | urs al urs al eral D | | One Continue 15 houtstand Delivery | | | |
| | Hos 24 ho Fun etely f | Medical | 29a. Certifier (Check only one) 1★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 1★ Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred and manner stated. | and due to the cause red at the time, date | (s) and manner as and place, and due | stated. to the cause(s) |
| | To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director; page 2 should be detached for use as the burial-transit | Me | 29b. Signature and title of certifier 29c. License number | 29d. | Date signed (Month | , Day, Year) |
| | (2 | | M3/4m D38471 | 1 | 1/12/06 | |
| | フ | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | | |
| | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 227 (Tefferson Blud Smithsberg MS 31. Date filed (Month, Day, Year) NOV 13 2006 32. Registrar's Signature | 21783 Wi | Iliam B. | Kerns, M.D. |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 1 3 2006 32. Registrar's Signature | | | |
| | negisti | aı | MAN TO TOO TOO TOO TOO TOO | | | |

DHMH 17 Rev 1/2001

Frances L. Grove

| | | | 1 - For State Registrar | State of Mai | ryland / | | artmeni <i>rtificate</i> | | | men | | ene 2 (| 06 | 37902 |
|---------------|--|----------------|--|--|---------------------------|-------------------|-----------------------------|-----------------------|--|----------|-----------------------------|----------------------|------------------------|--|
| | Physici | an | 1. Decedent's Name (First, Middle, La | • | | | | | | ħ | ate of Death | Day | Year | 3. Time of Death |
| | /Medic | | Helen Elizabeth 4a. Facility Name (If not institution, gi | Grissam | | | 4b Ciby | Town or I | ocation of Deat | - | Vovemb | | y of Death | 6:00 P ^M |
| | Examin | er | Washington Adver | | tal | | 40. City, | | ma Park | | | | ntgom | 020 |
| | Funeral Director | | Social Security Number 6. | | (In yrs. last t | oirthday) Yrs. | If Under Months | 1 Year Days | If Under 24 Hrs Hours Min. | . (1 | ate of Birth Month, Day, | Year) | 9. Birthp Coun | ace (State or Foreign try) |
| 4 | 2 - | | 577-09-6423 Usual Residence of Decedent | | 96 | | | | | Jı | ily 24 | , 1910 | Wash | ington, DC |
| | ylanc | | 10a. State 10b. County | | 10c. City, To | wn or Lo | cation | | | | | | 1 | 0d. Inside City Limits |
| | the Mar | Director | Maryland Prince 10e. Street and Number | George's | Hyatt | svil | le 10f. Zip | 0-4- | | | | - 011 | 140 | 1 ☐ Yes 2 ☐ No |
| | with so of | | | | | | 101. Zip | | | | 10 | g. Citizen of | | try r |
| | ne 23 | Funerai | 7003 23rd Place | 12. Was Decedent Ev | rer in U.S. | 13. \ | Was Deced | | 783 panic Origin? (S | Specify | Yes or No- | 14. Ra | USA ce Americ | an Indian. |
| 5-0036 | o 72 hours after death with the Maryland "natural", or Iteme 23a or 28a-f show sidical Examinar must be notified at | by Fur | 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | | | fYes,spec 1□Yes 2 | | panic Origin? (S , Mexican, Puerl Specity: | to Ricai | n, etc.) | | ack, White, o White | etc. |
| Ž | 72 hou nature | | 15. Decedent's E | ducation | 16 | a. Deced | lent's Usua | I Occupat | ion | | 1 | 6b. Kind of E | Business/Inc | lustry |
| 121 | within 7 ene. than "n | Completed | (Specify only highest gr Elementary/Secondary (0-12) 1.2 | college (1-4or 5+) |) | (Give life. I | | | ring most of wo | rking | | | | |
| 2 | filed Hygie Sther | Co | 17. Father's Name (First, Middle, Las | t) | | | CI | erk | 8. Mother's Nar | me (Fir | | | | rnment |
| ğ | ad be do | To Be | William John Gr | | | | | | | | raine | | , | |
| Mary | shou and M amar umat | _ | 19a. tnformant's Name/Relationship | (Type, Print) | 15 | b. Mailin | g Address | (Street an | id Number or Ru | | | | | Code) |
| Ž, | ss 1 end 2 should of Health and Me Item 27 is mark cother traumation | | Marjorie G. Rose | / Sister | | 7003 | 23rd | Plac | ce, Hyat | ttsv | ville, | Maryl | and 2 | 0783 |
| more | permit. Pages 1 of Depertment of He Important: If Item eny Injury or oth Once. | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci | | 20b. Place cemel | ery, cren | natory or ot | ther place) | Nove | | 13 | 0c. Location | | |
| | permit. F Depertme Importan eny injur | | 21. Signature of Funeral Service Lice | | react | | | _ | ·Collins | 200 | | | | Virginia |
| ñ | Depermine on transfer on trans | | Annedlar | ie Tarke | | | | | | | | | | , MD 20901 |
| | | | 23a. Part1. Enter the disease, or con shock, or heart failure. List only | nplications that caused the | ne death. Do | | | | | | | | pring | Approximate Interval Between |
| p 1 | Physician | | Immediate Cause (Final disease or condition | a. RESIS | | - | SEP | cic | | | | | | Onset and Death |
| | /Medical | | resulting in death) | Due to (or as a | | | 761 | داد | | | | | | ~ 20 augs |
| | Examiner | | S-puentially list conditions, | b. RESPI | | | r | FAIL | URE | | | | | |
| | ed sit | nlne | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a | consequence | a of): | 4.70 | | URE | | | | | |
| _ | executed on and ial-transit | Examiner | that initiated events resulting in death) Last | c. AS L | A 10 consequence | | PNG | su M | ONIA | - | | | | |
| 04/80 8/80 | licate be executed physicien and s the burial-transit | calE | | ď | | | | | | | | | | |
| Ω. | tificat ng phy as th | PG | | | | | | | | | | | | |
| X O D | The law requires that the death certif tte has been signed by the attending bage 2 should be detached for use a | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of 1 Live birth 2 | ☐ Fetel deal | | Ectopic pre | | | | | | ate of delive | ry Day Year |
| j. | the de | hysic | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 4□Pregnant at tir 9□ Unknown | ne or death | 5_ | Other (spe | ecity) | | | | | | |
| ν L | es thai gned t | by P | Part II. Other significant conditions | | not resulting | in the ur | nderlying ca | ause given | in Part I. | : | 23e. Did toba | acco use con | tribute to th | e cause of death? |
| ecoras, | een s | ted | DEMONTH | | | | | | | | 1 🗆 Yes | ≥√2 No | 3 🗌 Proba | ably 4 Unknown |
| ပို့ ပို | has b | Completed | | | | | | | | 2 | 24a. Was an autopsy | | prior to con | sy findings available apletion of cause of |
| Vital | Physician: The lav this certificate has al director, page 2: | | 05.11/ | | | | | | | | perform | No | death? 1 🗌 Yes | 2□ No |
| <u>=</u> | siclar centr irecto | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No | Hospital: Inpatient | 2□ EB/0 |) u tamati am | t 3□ DO | ! Other | 26. Place of Dea | | | | | |
| 5 | g Phy er this | n: To | 27. Manner of Death | 28a. Date of Injury (Month, Day) | | Time of | | Bc. Injury a Work? | 4 ☐ Nursing H | | Describe how | | |) |
| 0 | ath. rr: Aft | atio | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation | | rear) | Injury | м | | s 2 No | | | | | |
| UNISION | or Atte | Certification: | 3 Suicide 6 Could not to determined | 28e. Place of Injury building, etc. | / - At home, (Specify) | farm, stre | et, factory, | , office | | 28f. L | ocation (Stre | et and Num State) | ber or Rural | Route Number, |
| | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | | 29a. Certifier Certifying Pl | hysician: To the best of | my knowled | ge, death | occurred a | at the time | , date and place | , and d | ue to the cau | use(s) and m | anner as sta | ated. |
| | the H in 24 the F iplete | Medical | | nimer: On the basis of each manner state | d. | mayor inv | | | | irred at | | | | |
| | | 2 | 29b. Signature and title of certifier | nonse | | | | License | | | | d. Date signe | | * |
| | 12 | | | Noyer | | | | シー (| 7874 | | | /(- / | 1- 200 | 0.6 |
| | | | 30. Name and address of person who S. M. NAYAR | completed rause of dea | 717 – 3 | (Type, 1 | AVE | Co | TTAGE | c(| 14, 1 | ND 2 | 0722 | |
| | Sta Registr | | 30. Name and address of person who S. M. NAYAR 31. Date filed (Month, Day, Year) NOV 1. 4. 2 | 32 Registrar's | s Signature | 100 | nes | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Victoria Susana Garaycochea November 12, 2006 12:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Village Health Care Center Montgomery Village Montgomery 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🔀 F Director 217-44-5349 93 Aug. 11, 1913 Peru Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland | Montgomery Montgomery Village 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a or 19301 Watkins Mill Road 20886 USA Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Yes 2 No Specify:Peruvian SpeciMhite 2 3√ Widowed 4 Divorced Completed th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emilio Yanez Pastor Nicolasa Pastor Odriozola ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7061 Mill Run Circle, Naples, of Disposition (Name of Date Gloria Miguez/ Daughter Florida 34109 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of F ant: If Ite November 13, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one or use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hyper natremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated accounts Examiner Due to (or as a consequence of): that the death certificate be executed that initiated events <u>Azotemia</u> and burial-tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Anemia 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 415 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 2 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred Hospital or Attending Natural Natural Injury 5 Pending after death. 1 🗌 Yes 2 🔲 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D41162 November 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19529 Doctors Drive, Vinu Ganti, M.D. Germantown, MD 20874 31. Date filed (Month, Day, Year) egistrar's Signature State

DHMH 17 Rev 1/2001

Registra

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 2006 0 : 24 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** 9. Birthplace (State or Foreign 9/9/1927 Days Months Hours 1 □ M 2 🛛 F 79 WEST^{UN}VIRGINIA 236-40-8535 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location fshow 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at MD WASHINGTON HAGERSTOWN 1 □ Yes ½ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13003 RESH ROAD 21740 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXXNo Specify: WHITE Specify: þ 3XWidowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN BENJAMIN TYSON MARTHA VIRGINIA BARRETT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trai 13003 RESH ROAD, HAGERSTOWN, MD 21740 ROBIN GROVE/DAUGHTER 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State NOVEMBER 1 Burial 2 □ Cremation 3 □ Removal from State CENTRAL CHAPEL CEMETERY 14, 2006 4 □ Donation 5 □ Other (Specify) RFD HEDGESVILLE, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821. 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OFONAP disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi Due to (or as a consequence of) attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 1 Live birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 page autopsy performe certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA Other: P 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

be executed P.O. Box 68760, or Vital Records, Physician: Division or Attending To the Hospital

the Maryland

3altimore, Maryland 21215-0036

the Funeral Director: After this appletely filled in by the funeral directions. death. after within 24 hours a

To the Funeral I

29a. Certifier 29b. Signature and title of certifier

Medical

State

Registrar

and manner stated.

fxertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

| 00 | | addrass | -6 - | | | | | -6 | /14 | 00-1 | /T. | - |
|-----|------------|---------|------|-------|------|-----------|-------|----------|-------|------|--------|-----|
| 30. | ivanie and | address | or b | erson | WILC | completed | cause | or death | (Item | 23a) | (Type, | Pri |
| | | 11 - | A | , | | 1 | | | | A | - | |

Hallebe 31. Date filed (Month, Day, Year)

16 2006

predical 11110 32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrer Amend #26 per fh/phys 11-14 CENTIFICATE of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 4:25 P. M November 9, 2006 Margaret W. Genua /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12224 Dancrest Drive Clarksburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 920 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🖟 F Virginia 86 Director 225-01-4166 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County r then "naturel", or items 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 No Maryland Worchester Ocean City Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21842 U.S.A. 243 South Ocean Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene.
ant: if item 27 le marked other then "naturel", or item
117 or other traumatic event, the Medical Externment 1 Never Married 2 Married 1 ☐ Yes 2 → No Specify: Baltimore, Maryland 21215-0036 If Yes. Give Specify: White ģ 3 XWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie D. Wenger Clement Gier Reiter ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12224 Dancrest Drive, Clarksburg, Maryland 20871 Stephen M. Genua - Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
National Memorial Park 1 Burial 2 □ Cremation 3 □ Removal from State 11/13/06 Falls Church, Virginia 4 ☐ Denation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Molesworth-Williams P.A., Funeral Home Frest L 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Nonsmall cell lung cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 1 ☐ Yes 2 ☐XNo 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 □ No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Son's Other: 4 Nursing Home 5 Residence 6X Other (Specify Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours ener.
The Funeral Director: / investigation 2 Accident 6 Could not be determined 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 0 November 10, 2006 D35635 erson who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Drive - #327, Olney, Maryland 20832 Joseph Kaplan M.D., 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Day GALE Year **Physician** ARRIE 8,2006 Nevember /Medical nty of Death 4b. City, Town, or Location of Death Examiner IDAKO 31USb41 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 **F** 0-31-1940 MARYLAND Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No "natural", or items 23a or 28a-f sh edical Examiner must be notified Director 10g. Citizen of What Country? MORGAN DRIVE Funeral 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) F- WORKER 17. Father's Name (First, Middle, Last) erin ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18068 Morgan De. Lincoln, DE daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State Chance, Md 18/06 4 ☐ Donation 5 ☐ Other (Specify) SAlishuru, md 21804 Approximate Interval Between Onset and Death 23a. Part1. Ente shock, or h ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ications that caused the ne cause on each line Immediate Cause (Mal 24 hours **Physician** meumona disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine use as the burial-transit Causa (Disease of Inju that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 ☐ Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA ို 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury → Naturai 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

Box 68760. certificate be P.O. Division or Vital Records,

been signed by the s should be detached After this certificate has page funeral director, To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After filled in by the

attending physician

for

28a-f show

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

29c. License number

29d. Date, signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MM

th, Day, Year) 31. Date filed (Month 9 2006 0

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. UU6 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 04. GLENN HAYES 2006 3:15P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** FORT WASHINGTON PRINCE GEORGES FORT WASHINGTON HEALTH & REHAB | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MAY 27, 19 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 6 Sex XXM 2 F VIRGINIA Director 223 70 5834 54 Usual Residence of Decedent 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County ir than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at XXYes 2 □ No Directo MD PRINCE GEORGES SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3503 B TERRACE DRIVE 20746 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. ∏Yes 2XXNo Yes Give XX Never Married 2 Married 1 ☐ Yes XXNo Specify: If Yes, Give Year or Dates: BLACK Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ST. ELIZABETH'S HOSP. 10TH COUNSELOR other traumatic avent, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be EDWARD POSEY ROSIE M. HAYES ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If Itam 27 Is FRANCES GOWDY / SISTER 911 LOGWOOD ROAD CAPITOL HEIGHTS, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o XX Burial 2 Cremation 3 Removal from State A ☐ Donation 5 ☐ Other (Specify) HISTORLAND MEMORIAL PK. 11/11/06 KING GEORGE COUNTY, VA 21. Signature of Funeral Service Licensee 22. Marshall S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** irrhosis /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Cause (Ciscase or injur that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown ρχ s been signed by should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4XXUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 XXNo 1 ☐ Yes 25. Was case referred to medical director 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: XXNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XXNo Certification; To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attanding Injury XIX Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Hospital 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceptified D42955 NOVEMBER 14, 2006 30. Name and address of per who mpleted cap se of death (Item 23a) (Type, Print) 12017 FORT WASHINGTON RD. FT. WASH., MD 20744 POTTER, 32. Registrar's Signature 31. Date filed (Month, Day, Year State NOV 1 5 2006 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

| Donald Harrison, | | | State | of Maryla | | artment of | | and Me | ental Hy | /giene | | | | |
|---|---------------|---|-------------------------|---------------------------|---------------------------|--------------------------------------|------------------------------|---------------------|--------------|----------------------------------|--|--|--|--|
| | | 1- For State Registrar 1 Decedent's Name (First | A SELECTION I SELECTION | 4) | Cei | rtificate of | Death | | | 2. Date of Deat | g. No. 2 | 106 3790 | | |
| Physicia Medical Examir | | | | , | | | | | | Month November | | 1701 hrs | | |
| (> | | Donald F 4a. Facility Name (if not in | stitution, give | e street and nu | mber) | 4 | b. City, Town | , or Location | on of Death | November | 4c. County of | Death | | |
| | | Prince George's | | ospital | | | Cheverly | | | | Prince Ge | eorge's | | |
| Funeral | | 5. Social Security Number 577–76–8524 | | × | 7. Age (In yrs. I | ast birthday) | If Under 1 Months [| _ | urs Min. | 8 Date of Birt | h(MM/DD/YYYY) | 9. Birthplace (State or Foreign Wash., D.C. Country) | | |
| Director | | | 1,1 | M 2 F | 51 | Yrs | | Jayo | dio Willia | 12/5/ | 54 | Country) | | |
| à | | Usual Residence of Deceded 10a State 10b. C | | | 10c. City, | Town or Location | on | | | | | 10d. Inside City Limits | | |
| nd ihow a | _ | Md. Pr | ince (| George' | s | | Seat : | Pleas | ant | | | 1 X Yes 2 No | | |
| tarylar 28a-f s | Director | 10e. Street and Number | | | | | 10f. Zip Cod | е | | 10 | g. Citizen of Wha | at Country? | | |
| 1 the N | | 612 64th F | lace | | | | | 2074 | 3 | | U.S. | A. | | |
| th with | Funeral | 11, Marital Status 1 Never Married 2 | Married | | edent Ever in U prces? | | Decedent of s, specify Cu | | | ecify Yes or No- Rican, etc.) | 14. Race - White, | American Indian, Black, etc. | | |
| er dea | | 3 Widowed 4 | | 1 Yes | 2 X No | | | No speci | | | Specify: | African- American | | |
| urs aft. | ð | 15. Decedent's Educatio | | or Dates: | | 16a. Decedent | 's Usual Occu | upation (Gi | ve kind of w | ork done | 16b. Kind of Bus | | | |
| 3 72 hou n "nai | etec | Elementary/Secondary | (0-12) | College (1 | -4 or 5+) | during mo | st of working | life DO NO | OT use retir | red) | County Mainte | nance | | |
| 5-0036 lled within 7 Hygiene. I other than | Completed | 12th | | | | Lal | orer | ., | | | | nance | | |
| 15-C | | 17. Father's Name (First, I James Har | | | | | | 18.Moth | | (First, Middle, N ie Warre | Maiden Surname) | | | |
| 2121 buld be fi Mental I marked c event, | To Be | 19a. Informant's Name/Re | · · | | | 19b. Mailing | Address (S | treet and N | | | ral Route Number, City or Town, State, Zip Code) | | | |
| MD d 2 sho lth and n 27 is aumatia | | James Harri | son,Si | ./Fath | er | I | | | | easant, | | | | |
| | | 20a. Method of Disposition 1 X Burial 2 Cre | | Removal fro | | Place of Disposi crematory or oth | | cemetery, | | Date | 20c. Location - 0 | City or Town, State | | |
| altimore, mit. Pages I at epartment of He portant: If ite jury or other tr | | | her Specify: | | | . Olivet | Cem. | | 117 | /20/06 | Washing | ton D.C. | | |
| Balti permit. Departr Import | | 21 Signature of Funeral S | ervice Licen | see P | -77 | 22. N | S Was | ress of Fac hing | ility | Sons Co | o. The | aton, D. C. 20019 | | |
| | | 23a. Part I. Enter the | PV PV | ilications that ca | au sad the death | Do not enter th | 925 Bu | rrouc | ghs Av | e.,N.E. | Washing | ton, D.C. 20019 | | |
| Physician /Medical | | failure. List only one | cause on ea | ach line. | adout the double | , Do not onto a | o modo or dy | irig, baoir a | o daraido o | roopiiatory are | or, shook, or hour | Between Onset and Death | | |
| xaminer | | Immediate Cause (Final door condition resulting in do | | Asphyxia Due to (or as a | consequence o | of): | | | | | | | | |
| | | Sequentially list condition | | | | | | | | | | | | |
| | jine | if any, leading to immedia cause. Enter Underlying | Cause | Due to (or as a | consequence o | of): | | | | | | | | |
| p. sit | Examine | events resulting in death) | | Due to (or as a | consequence o | of): | | | | | | | | |
| 0, e be executed rsician and burial - transit | dical | UNPENDED | d. | AMENDED | | | 0 14 104 1 | | . | | | | | |
| 50, te be e | | IF FEMALE: | -A | 23c If yes | #1,perME | g862, 1 | 2/6/06 ' | Т | | | 23d. Date of d | elivery | | |
| Box 6876C he death certificate the attending phys hed for use as the b | ician/Me | 23b. Was decedent pregna past 12 months? | int in the | 1 Live b | irth | 2 Fet | al death | 3 Ecto | opic pregna | ncy | Month | Day Year | | |
| Box (e death ce the attended for use | S | 1 Yes 2 No 9 | Unknown | | ant at time of de | eath 5 Oth | er (Specify) | | | | | | | |
| O. B at the da d by the | Phy | Part II. Other significant | conditions | | | esulting in the u | nderlying cau | se given in | Part I. | 23e. Did to | bacco use contrib | ute to the cause of death? | | |
| of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by the thereal director, page 2 should be detached. | d by | Hypertensive ca | rdiovascu | ılar disease | | | | | | 1 Yes | 2 No 3 | Probably 4 Unknown | | |
| rds, requir | Completed | | | | | | | | | 24a, Was a | | ere autopsy findings available ior to completion of cause of | | |
| of Vital Records by Physician: The law requi | dwc | | – | | | | | | | perfor | med? de | eath? Yes 2 No | | |
| | o l | 25. Was case referred to | medical | | | | 26.P | lace of Dea | ath (Check o | | | | | |
| Vita hysici this co | To B | examiner? | lo H | Hospital: 1 1 | Inpatient 2 🗸 | ER/Outpatient | | Other ₄ | | g Home 5 | Residence 6 | Other: | | |
| | | 27. Manner of Death Natural 5 | 1 = 1 | 28a. Date FOUND | of Injury Day,Year) | 28b. Time of Ir FOUND: | · · _ | Injury at W | | 28d. Describe t Subject was | now injury occurred assaulted | d | | |
| Sior Attence death cetor: | catic | 2 Accident | Pending Investigati | on Nov 12, | 2006 | 1555 hrs | 1_ | Yes 2 | | 20f Laustina (6 | the of and bloombar | Donal Donate Marshare City | | |
| Division pital or Attendi ours after death reral Director: / | ertification: | 3 Suicide 6 | Could not determine | be | Single Far | iome, farm, stree milv | i, raciory, om | ce building | | or Town, S | | or Rural Route Number, City | | |
| Hospit Hour Funer | ပ | 4 Homicide 29a Certifier (Check only 1 Certif | ying Physici | | | | ed at the time | e, date and | | | e(s) and manner a | | | |
| Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director. | Medical | | al Examine | r:On the basis of | | and/or investigati | on, in my opi | nion, death | occurred a | t the time, date | and place, and du | e to the cause(s) | | |
| F 3 F 3 | Re | 29b Signature and title of | certifier | | | | | ense numb | per | | | (Month, Day, Year) | | |
| | | Yamel Four | hall m | (2) | | | 0. | .C.M.E. | | | November 1 | 3, 2006 | | |
| | 1 | 30. Name and address of Pamela E. South | | · | se of death (Iten | | l Penn Str | oot Rali | timore 1 | MD 21201 | | | | |
| //- | ato | 31. Date filed (Month, Day | | | egistrar's Signati | uro. | | CCL Dall | unoie, N | | <u> </u> | | | |
| Regist | | | 2006 | have | ~ B. | fred | | | | | | | | |

| | | | 1- For State of Maryland Registrar | | artment of H | | - | giene Reg. No. 006 | 37909 |
|--|--|-------------------|---|----------------------|---|--|------------------------------------|---|--|
| | Physic /Medi | | Decedent's Name (First, Middle, Last) Charles Edward Hazzard | | | | 2. Date of De Month NOV • | Day Year 9, 2006 | 3. Time of Death |
| | Examir | | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, o | r Location of Death | | 4c. County of De | |
| | E Y | | 5006 Silver Hill Road #B | | Suitlan | | | Prince (| |
| | Funeral Director | | 5. Social Security Number 6. Sex 1 ⋈ M 2 □ F 7. Age (In yrs. last | Yrs. | If Under 1 Year Months Days | Hours Min. | 8. Date of Bird (Month, Da | th 9. Bi y, Year) (| rthplace (State or Foreign country) |
| | v | | Usual Residence of Decedent | | | | June 1 | 3, 1958 DC | |
| | i within 72 hours after death with the Maryland liene. I then "natural", or flems 23a or 28a-f ehow the Mudical Examiner must be notified at | - | 10a. State 10b. County 10c. City, T MD Prince Georges Suit | | cation | | | | 10d. Inside City Limits |
| | the M. | Director | 10e. Street and Number | Lana | | | | | 1 ☐ Yes 2 No |
| | Sa or | | 5006 Silver Hill Road #B | | 10f. Zip Code 2074 | c | | 10g. Citizen of What C | ountry? |
| | death | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. | 13. \ | | O lispanic Origin? (Sp an, Mexican, Puerto | ecify Yes or No | U. S. A. | erican Indian. |
| 9 | or its | | Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give | | f Yes, specify Cuba I□ Yes 2 X No | | Rican, etc.) | | |
| 8 | ural', | d by | 3 Ø Widowed 4 □ Divorced Year or Dates: | | TE Tes ZALINO | Specify: | | Specify: B | Lack |
| 15 | n 72 in at | Completed | (Specify only highest grade completed) | (Give | lent's Usual Occup kind of work done DO NOT use retired | during most of work | ing | 16b. Kind of Business | :/Industry |
| 212 | d within piene. r then " | ошь | Elementary/Secondary (0-12) College (1-4or 5+) | | Cutter | -/ | | Food indus | strv |
| D . | be filed stal Hygid of other | Be C | 17. Father's Name (First, Middle, Last) | | | 18. Molher's Nam | e (First, Middle, | Maiden Sumame) | |
| yla | should be not Mental marked c | To | Haywood David Hazzard | | | Dorothy | | | |
| , Maryland 21215-0036 | iges 1 and 2 should be nt of Health and Menta if item 27 is marked or other traumatic ev | | 19a. Informant's Name/Relationship (Type, Print) Dorothy Hazzard — mother | 19b. Mailin 224 R | St. NW, | and Number or Rur #102, Wa | a <i>i Route Numbe</i> shingtor | n, City or Town, State, n, DC 2000] | Zip Code) - |
| | Pages 1 nent of H int: If iter iry or oth | | 1 ☐ Burial 2 【Cremation 3 ☐ Removal from Slale | etery, crem | sition (Name of natory or other place tan Crema | atory 11- | 15-06 | 20c. Location - City of | |
| alti | permit. Page Department of Important: If eny injury or once. | | 21. Signature of Fune al Service Licensee | | | | | nson Funera | al Homo DA |
| <u> </u> | 83558 | | JUDIAL D JOHNSON | 65 | 03 Old Br | anch Ave | ., Temp] | le Hills, M | D 20748 |
| E | | | 23a. Part. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. | Do not ente | er the mode of dyin | g, such as cardiac | or respiratory ar | rest, | Approximate Interval Belween |
| 10 | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | Nou | d to | Head | | | Onset and Death |
| | Examiner | | Due to (or as a consequent | ce of): | | | | | |
| | | Jer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | ce of): | | | | | |
| | cuted nd ransit | Examiner | that initiated events | | | | | | |
| Ö, | ate be executed hysician and ihe burial-transit | I Ex | resulting in death) Last Due to (or as a consequent | ce of): | | | | | |
| 8760, | icate be executed physician and s the burial-transit | Physician/Medical | d | | | | | | |
| 9 x | that the death certific ed by the attending pl detached for use as t | /Me | IF FEMALE: 23c. If yes, outcome of pregnancy | , | | | | | |
| Вох | death a atter d for u | iciar | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death | ath 3 🗆 | Ectopic pregnancy Other (specify) | | | 23d. Dale of de Month | livery Day Year |
| P.O. | that the de ned by the a detached t | hys | 9 ☐ Unknown | | | | | | |
| Ś | res tha igned be det | by P | Part II. Other significant conditions contributing to death but not resultin | g in the un | derlying cause give | en in Part I. | 23e. Did to | bacco use contribute le | the cause of death? |
| ord | The law requires tte has been sign page 2 should be | Completed | | | | | 1 🗆 Y | es 2 No 3 P | robably 4 Unknown |
| 3ec | e law has t je 2 s | μpi | | | | | 24a. Was a autops | sy prior to | utopsy findings available completion of cause of |
| | (0) | e Co | 25. Was case referred to medical | | | | perfor 1 ☐ Yes | 2₽No 1□Yes | 2 □ No |
| 5 | Physician: rthis certifica ral director, | To Be | examiner? | (Qutnation) | 3□ DOA Othe | 26. Place of Death | | ence 6 □Other (Spe | |
| Division of | ding Phys h. After this funeral di | | 27. Manner of Death 28a. Date of Injury 28t | b. Time of Injury | 28c. Injury Work | | | ow injury occurred \$2 | |
| <u>S</u> | Attending ir death. ector: After by the fune | satic | 2 Accident investigation November 9 200 | 6 112 | | res 2- No | gunski | wound f | dera |
| <u>\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ </u> | l or Atten after deati Director: I in by the | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, elc. (Specify) | , farm, stre | et, factory, office | | 28f. Location (Si City or Town | treet and Number or Rin, State) | ural Route Number, |
| _ | potal cours a leral (| S | 29a. Certifier 1 Certifying Physician: To the best of my knowler | 00 | me | | Rund, S | custand. | reary land |
| | To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director, | edicai | 29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowled to the basis of examination and manner stated. | and/or inv | estigation, in my op | pinion, death occurr | ed al the time, d | ause(s) and marmer as ate and place, and due | s stated." e to the cause(s) |
| | To the Hospital within 24 hours a To the Funeral Completely filled | Me | 29b. Signature and title of certifier | | 29c. License | number | 12 | 9d. Date signed (Mont | h, Day, Year) |
| | | | forward Blogton 00 | | HOO. | 55927 | | brent-1 | 15, 2006 |
| 12 | 0 | | 30. Name and address of person who completed cause of death (Item 23 | a) (Type, P | rint) | -1 /1 | 200 | Vovember | |
| | Sta | te | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | 16 10 | y orr | - Ly C | and a | my 1 | N of |
| | Registr | | NOV 1 6 2006 Been D. P. | redit | , | | • | | |

| | | | State of Maryland / Department of Health and Me 1 - State Registrer Certificate of Death | | eg. No. | 3/910 |
|--------------------------------|---|-----------------------|--|---|---|--|
| | Physici | | The personal formation of the personal forma | Date of Deat Month | Day 2 Year | 3. Time of Death |
| | /Medic Examin | | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death | | 4c. County of Dea | ath |
| | | | 13503 Cherry Tree Circle Hagerstown | | Washing | |
| | Funeral Director | | 220-09-9451 Ji | Date of Birth (Month, Day, uly 19 | , 1916 Ma | rthplace (State or Foreign country) ryland |
| | yland 10w | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits |
| | Mar | ctor | Maryland Washington Hagerstown | | | 1 ☐ Yes 2⊠ No |
| | h with the | ai Dire | 10e. Street and Number 13503 Cherry Tree Circle 21742 | 1 | 0g. Citizen of What C | ountry? |
| Baltimore, Maryland 21215-0036 | should be filed within 72 hours after death with the Maryland nd Mentel Hygiene. marked other then "naturel", or Items 23s or 28s-1 show marked other than "naturel", or Items 23s or 28s-1 show matic event, the Madical Exempler mail the mailined at | 1 by Funeral Director | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 3 ☑ Wildowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Specify Cuban, Mexican, Puerto Rice If Yes, Since Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rice If Yes, Since Year or Dates: | y Yes or No- can, etc.) | 14. Race - Am Black, Wh Specify: Wh | ite, etc. |
| 5-0 | n 72 hours "naturel", | etec | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business | s/Industry |
| 2121 | permit. Pages 1 and 2 should be filed within 72 ho Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other then "natur eny Injury or other treumatic event, the Madical ADGE. | Be Completed | Elementary/Secondary (0-12) College (1-4or 5+) 0-12 College (1-4or 5+) homemaker | | her own | home |
| פֿל | e filed al Hyg other | 3e C | 17. Father's Name (First, Middle, Last) 18. Mother's Name (F | | | |
| ylaı | Ment Ment arked | Tol | charles westey dam. | Clara | Newman | |
| Mar | d 2 sh th and t7 te m treum | | 19a. Informant's Name/Relationship (Type, Print) Samuel C. Hershey - son 19b. Mailing Address (Street and Number or Rural F | | | |
| ē, | of Heat Item 2 | | 20a. Method of Disposition 20b. Place of Disposition (Name of Campley Crematory of other place) | е : | 20c. Location - City o | r Town, State |
| timo | Page Iment c tant: If jury or | | 4 Donation 5 Other (Specify) Rose Hill Cemetery 16, 20 | 06 1 | | , Maryland |
| Ball | permit. Depertr Imports eny Inj | | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minn 415 East Wilson Blvd. | | | |
| | Physician /Medical Examiner | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): | / | est, | Approximate Interval Between Onset and Death |
| 68760, | icate be executed physicien end s the burial-transit | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d. | | | |
| P.O. Box 6 | Attending Physicien: The law requires thet the death certif ridesh. setor: Atter this certificete has been signed by the ettending by the tuneral director, page 2 should be detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknow | | 23d. Date of de Month | blivery Day Year |
| | res thet igned b | þ | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tob | 1 | to the cause of death? |
| Sord | v requi | eted | A GISTAL COLORS | 24a. Was a | 7 | outopsy findings available |
| Rec | The lay | Completed | | autops perform | ned2 prior to death? | completion of cause of |
| ital | len: artifice ctor, p | BeC | 25. Was case referred to medical examiner? | | | |
| > > | Physic this ce al dire | 은 | 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home | | ence 6 Other (Sp | ecily) |
| o uc | fing P | lon: | Natural 5 Pending (Month, Day Year) Injury Work? | d. Describe no | ow injury occurred | |
| Division of Vital Records, | or Attendi after deeth. Director: A in by the ft | Certification: | 2 Accident | f. Location (St. City or Town | treet and Number or F n, State) | Rural Route Number, |
| _ | To the Hospital or Attending Physicien: The law within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Medical Ce | 29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and and manner stated. Check only one) | d due to the ca at the time, da | ause(s) and manner a ate and place, and du | s stated. e to the cause(s) |
| | To the within To the comple | Me | 29b. Signature and title of certifier Dun 1 Albaham 29c. License number Do 265 | 23 1 | 9d. Date signed (Mor | (13, 17) |
| 31 | 1-4 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Por 12 (An) | 1907 | J, HXGE | MANIN |
| | Sta Registi | | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | | 117 |

| | | | 1 - For State Registrar | State of Maryla | | artment rtificate | | | nd Mental | Hygien | ZUUb | 37911 |
|-------------------|--|---------------------|---|--|---|---|-----------------------------------|--|--|----------------------------------|--|--|
| | Physici | | Decedent's Name (First, Middle, Last FRANCES MILDRED I | • | | | | | Mont | | 10. 20 | 3. Time of Death r 06 9:58 A |
| | /Medic Examir | | 4a. Fecility Name (If not institution, give | street and number) | | 4b. City, 1 | Town, or | Location of t | | | c. County of De | |
| | | | RAVENWOOD LUTHERA | | | HAGE | | | Um I | | WASHING | |
| | Funeral Director | | 217-30-1346 | x 7. Age (In yrs | . last birthday) Yrs. | If Under Months | Days | If Under 24 Hours | Min. (Mont | of Birth h, Day, Yea 6,19(| | irthplace (State or Foreign Country) aryland |
| | land | | Usual Residence of Decedent 10a. State 10b. County | 10c. C | ity, Town or Lo | ocation | | | | | | 10d. Inside City Limits |
| | Many a-f sho | tor | Maryland Washing | ton H | lagerst | own | | | | | | 1 ☑ Yes 2 ☐ No |
| | or 284 | Direc | 10e. Street and Number | | | 10f. Zip | Code | | | 10g. C | Citizen of What | Country? |
| | s 23a | rai | 739 S. Potomac S | | 10 | | | L740 | | | USA | |
| 5-0036 | n 72 hours after deeth with the Maryland "natural", or Items 23a or 28a-1 show safted Exametrers be traffiled at | by Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: | | Was Decedi If Yes, speci 1 Tyes 2 | | spanic Origin n, Mexican, F Specify: | n? (Specify Yes Puerto Rican, etc | or No- 2) | 14. Race - An Black, Wi Specify: W | |
| 215-0 | c * 3 | Completed | 15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) | ucation de completed) College (1-4or 5+) | 16a. Dece (Give life. | dent's Usual kind of word DO NOT us | Occupa k done di e retired) | tion uring most o | f working | 16b. | Kind of Busines | ss/Industry |
| 2 | filed with Hygiene other the | Com | 12 | 0 | ho | omemak | er | | | h | er own | home |
| Maryland | ges 1 and 2 should be filed within to f Health and Mental Hygiene. If tiem 27 le marked other than or other traumatic event, the Me | To Be | 17. Father's Name (First, Middle, Last) George Lefever | | | | | | Name (First, M | | an Sumame) | |
| Mar | 12 sho h and 7 le mu raum | | 19a. Informant's Name/Relationship (T) | | | | | | or Rural Route N | | | |
| | permil, Pages 1 and 2 Department of Health a Important: If item 27 le any injury or other tra once. | | Kevin Spessard - 20a. Method of Disposition | | 1/406 Place of Dispo cemetery, crer | West | Was | hingt | on St., | | Stown, | Md. 21740 |
| o E | Pages ent of nt: If it | | 1 Burial 2 ☐ Cremation 3 ☐ No. 14 ☐ Donation 5 ☐ Other (Specify) | | | | | | 1/15/06 | | | , Maryland |
| Baltimore, | permit. I Departm Importai any injui | | 21. Signature of Funeral Service Licens | | 11.00 | Name and | | | | | UNERAL | |
| B . | 88 5 8 | | 23a. Part1. Enter the disease, or com |)///www | 1 | | | | lvd., Ha | igerst | | |
| 8760, | Physician physic | cai Examiner | shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to for as a consect. Due to (or as a consect.) | Quence of): | to | tr | ou nive | | | | Interval Batwaen Onset and Death Encury Linguistic |
| O. Box 6 | The law requires that the death certificate be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown | aldeath 3□ | Ectopic pre Other (spe | | | | | 23d. Date of d Month | elivery Day Year |
| ds, P. | uires that signed b ld be deta | þ | Part II. Other significant conditions co | ntributing to death but not re | sulting in the u | nderlying ca | use givei | n in Part I. | | | use contribute | to the cause of death? |
| of Vital Records, | sician: The law requir s certificate has been si irector, page 2 should I | Completed | | | | | | | | Was an autopsy performed? | prior to death? | autopsy findings available completion of cause of |
| ital | an: T rtifficat tor, pa | Be Co | 25. Was case referred to medical | | | | | 26 Place of | 1 ☐ Y | | lo 1□Y€ | es 2 No |
|) į | Physician: this certificatal director, I | To B | examiner? 1 ☐ Yes 2 🔀 No | Hospital: 1 Inpatient 2 | ER/Outpatien | t 3 00/ | Other | | ng Home 5 | | 6 ☐Other (Sp | ecify) |
| o uoi | ding After fune | | 27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28 M | c. Injury Work' 1 Y | at ? es 2 □ No | 28d. Desc | | ury occurred | |
| Division | i Sir G | Certification; | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At h building, etc. (Speci | nome, farm, str | eet, factory, | office | | 28f. Locat City o | ion (Street a r Town, Sta | and Number or F te) | Rural Route Number, |
| | To the Hospital or within 24 hours afte To the Funeral Dirc completely filled in I | Medicai | 29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exami | sician: To the best of my known: On the basis of examinating and manner stated. | owledge, death ation and/or inv | occurred a vestigation, | t the time in my opi | e, date and prinion, death of | place, and due to occurred at the t | the cause(ime, date ar | s) and manner and place, and du | as stated. ue to the cause(s) |
| | ro the within ro the | Me | 29b. Signature and title of certifier | 11 211-01 | | | License | | | 29d. D | ate signed (Mor | nth, Day, Year) |
| 1 | ۵ | | Mayen | J'suaj | 7 | | DI | F36 | J | | 11-10 | -06. |
| 4 | 3 | | 30. Name and address of person who co | ompleted cause of death (Itel | m 23a) (Type, | Print) | uil | LSM | cet H | ciges | erino 1 | -06. |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 32 negistrar's Sign | ature | wills) | | | | | | |

| | | • | For State Registrar | State of Mary | • | artment of H ertificate of L | | | ene 2006 | 37912 |
|--------------------------------|---|----------------|---|---|------------------------------|---|--------------------------------|-----------------------------------|---|--|
| F | Physicia | an | 1. Decedent's Name (First, Middle, La | | T | | | 2. Date of Deat Month | Day Year | |
| 3 | /Medic | al | Edythe A. 4a. Facility Name (If not institution, giv | Ha e street and number) | Ke | 4b. City, Town, or | Location of Death | Novemb | er 7, 2006 | |
| | Examin | er | Holy Cross Rehab | | Center | | nsville | | Montgomer | У |
| | Funeral | | 5. Social Security Number 6. S | | yrs. last birthday, Yrs. | | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, | | irthplace (State or Foreign Country) |
| | Director | | 579-18-1403 Usual Residence of Decedent | 8 | 16 Trs. | | | oct. 16, | 1920 M | aryland |
| | yland how | | 10a. State 10b. County | 100 | c. City, Town or L | ocation | | - | | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No |
| | Ba-f s | Director | | gomery | Silver | Spring | | | 0g. Citizen of What C | |
| | with the sa or 2 | | 10e. Street and Number 3398 Gleneagles | Drive. Ant. | 3D | Tor. Zip Code | 20906 | 1 | USA | ountry : |
| | death | Funeral | 11. Marital Status | 12. Was Decedent Ever | | Was Decedent of Hi If Yes, specify Cuba | | ecify Yes or No- | | nerican Indian, |
| Baltimore, Maryland 21215-0036 | be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Itams 23a or 28a-f show event, the Medical Examiner must be portified a | þ | 1 ☐ Never Married 2 ☐ Married 33 € Widowed 4 ☐ Divorced | 1 Tes 2 No If Yes, Give Year or Dates: | | 1 ☐ Yes 2X No | | Thours, old., | Specify:Wh | • |
| <u>2</u> | n 72 h | letec | 15. Decedent's E (Specify only highest gr | ducation ade completed) | 16a. Dece (Give | edent's Usual Occupa e kind of work done o DO NOT use retired | ation during most of work | ing | 16b. Kind of Busines | s/Industry |
| 12 | within lene. than | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | | pervisor | , | | Telecommu | nications |
| <u> </u> | e filed al Hygid other vent. | Be C | 17. Father's Name (First, Middle, Last | | | | 18. Mother's Name | | | |
| ylai | | Tof | Theodore F. Sch | | | | | ed Towns | | |
| Ma | s i and 2 should i Health and Mer item 27 is marke other traumatic | W I | 19a. Informant's Name/Relationship (Gerald L. Hake/ S | | | | | | City or Town, State, | |
| re, | of Health of Health I item 27 r other tr | | 20a. Method of Disposition | 2 | 0b, Place of Disp | | | Date | 20c. Location - City of | |
| Ē | Pages Tent of I ant: If its ury or o | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci | fy) M | | an Crematory | inover | mber 7, 2006 A | lexandria, | , Virginia |
| Balt | permit. Pages Depertment of Important: If it eny injury or o | | 21. Signature of Funeral Service Lice | | J. | | | | Home Inc | ng, MD 20901 |
| | | | 36a. Part1. Enter the disease, or con shock, or heart failure. List only | plications that caused the one cause on each line. | death. Do not er | nter the mode of dyin | g, such as cardiac | or respiratory arr | est, | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a. Congestive | | Failure | | | | |
| | Examiner | | West Transport and Department of the Party | Due to (or as a co | | z Heart Di | sease | | | |
| | ج. و | Iner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a co | | | | | | |
| | end end I-trans | Examin | Cause (Disease or injury that initiated events resulting in death) Last | c Due to (or as a co | nseguence of): | | | | | - |
| 68760 | ficate be executed physician end is the burial-transit | | | d | | | | | | |
| _ | ± 00 eg | Medical | IF FEMALE: | | | | | | | |
| Box | aath certif ettending for use as | Physician/M | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of p | Fetal death 3 | □Ectopic pregnancy | | | 23d. Date of d Month | lelivery Day Year |
| P.O. | res that the de signed by the e t be detached f | ysic | 1 □ Yes 2 □ No 9 □ Unknown | 4∏Pregnant at time 9☐Unknown | e or death 5 | Other (specify) | | | | |
| ري ص | s that pned b | by Pr | Part II. Other significant conditions | contributing to death bul no | ot resulting in the | undertying cause give | en in Part I. | 23e. Did tol | pacco use contribute | to the cause of death? |
| ord | v require been sig should t | | | | | | | 1 🗆 Ye | | Probably 4 Unknown |
| Division of Vital Records, | S 5 | Completed | | | | | | 24a. Was a autops perform | ned? death | autopsy findings available o completion of cause of ? es 2 \(\text{No}\) |
| Vita | ician: certific ector, | Be | 25. Was case referred to medical examiner? | Hospital: | | ont 30 DOA Oth | 26. Place of Deat | | | |
| ō | Phys arthis araldii | 1:10 | 1 ☐ Yes 3⁄2 No 27. Manner of Death | 28a. Date of Injury | 2 ER/Outpatie | of 28c. Injun | 4 K I Marshing File | | ence 6 Dother (Sp ow injury occurred | secify) |
| ion | Attending Physician: r death. ector: After this certified by the funeral director; | ation | 1 xNatural 5 ☐ Pending 2 ☐ Accident investigation | | pa <i>r)</i> Injury | | k? Yes 2 □No | | | |
| Divis | 5 # 5 E | Certification: | 3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined | | At home, farm, s Specify) | street, factory, office | | 28f. Location (Si City or Town | | Rural Route Number, |
| | Hospital 24 hours e Funeral letely filled | Medical (| | hysician: To the best of m miner: On the basis of exa and manner stated | amination and/or i | | | | | |
| | To the To the Complet | Me | 29b. Signature and title of certifier | 7.12 | 4 | 29c. Licens | e number | 2 | 9d. Date signed (Mo | nth, Day, Year) |
| | 7 | | Klorg | " Nano | slac | | 2121 | | November | 7, 2006 |
| | 1 | | 30. Name and address of person who George F. Sengs | | | _{9,Print)} cara Drive | e, Wheaton | n, MD 20 | 906 | |
| | Sta | | 31. Date filed (Month, Day, Year) | 22 Maintrada | | | | , | | |
| | Regist | ar | NOV UO | LUUU MINERA | 15 /5 | | | | | |

| 6-08518 | | | lease Type or Pri | | | | | |
|--|---------------|---|---|--|-------------------------|---------------------------------|---------------------------|----------------------------|
| larvin Walter H | | | aryland / Departm | | nd Mental Hyg | giene | | |
| | | l- For State Registrar | Certific | ate of Death | | Reg. | No. 2006 | 3791 |
| Physicia | | Decedent's Name (First, Middle,Last) | | | | Date of Death | | 3. Time of Death |
| /ledical Exami | | MARVIN WAL | TER HARDI | NG | i | Month D November 8 | , 2006 Year | 1851 hrs |
| | | 4a. Facility Name (if not institution, give street | and number) | 4b. City, Town, o | r Location of Death | - | 4c. County of Death | |
| | | Howard County General Hospita | al | Elkridge | | | Howard | |
| Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. last bir | thday) If Under 1 Ye | ar If Under 24Hrs. | 8. Date of Birth(| MM/DD/YYYY) 9. Birth | place (State or |
| Director | | | | Months Da | ys Hours Min. | Tinno | Foreign | ntry) Ma waz I a n |
| | Ļ | 219-02-9612 XM 2 | F 39 | Yrs. | | June 2 | 23,196/ 000 | ntry) Marylan |
| 2 | - | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town | or Location | | | - 1 . | Od. Inside City Limits |
| # S | Ì | MD Howard | 100. 010, 70.01 | Jessup | | | | 1 X Yes 2 No |
| and Fsho | ō | MD HOWAIG | | | | | | |
| th the Maryland 23a or 28a-f show any notified at once. | Director | 10e, Street and Number | | 10f. Zip Code | | 10g. | Citizen of What Count | ry? |
| the N | 声 | 8213 Lincoln D | rive | 20 | 794 | | U.S.A. | |
| ath with thems 23a | ᅙ | | /as Decedent Ever in U.S. | 13 Was Decedent of H | ispanic Origin? (Spec | cify Yes or No- | 14. Race - America | an Indian, Black, |
| eath r | Funeral | 1 Never Married 2 Married A | rmed Forces? | If Yes, specify Cuba | an, Mexican, Puerto R | ican, etc.) | White, etc. | |
| er d | | 3 Widowed 4 Divorced If Yes, | Yes 2 X No Give Year | 1 Yes 2 X N | o specify: | | Specify Bla | ack |
| rs afi ural' | چ | 15. Decedent's Education (Specify only high | es: | Decedent's Usual Occupa | | rk done | 6b. Kind of Business/Inc | dustry |
| hou 'nat | 달 | | ollege (1-4 or 5+) | during most of working lif | | | | |
| 15-0036 Tited within 72 Hygiene d other than " | Completed | llth. | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Self-empl | Loved | | Mechan | i |
| with with her t | 등 | 17. Father's Name (First, Middle, Last) | | Petr-emb | 18. Mother's Name (F | First Middle Mai | | |
| 215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene riked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once | | | 33 | | | | 1 | |
| 21215-0036 uld be filed within 72 hours after Mental Hygiene marked other than "natural", c event, the Medical Examiner | o Be | Walter A. Har 19a, Informant's Name/Relationship (Type, Pr | | b. Mailing Address (Stre | | | Bennett State | 7:- Code) |
| | \vdash | | · . | - ' | | | | |
| imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is ro or other traumatic | ļ | Walter A. Hardin | | 8213 Linco | | | Oc. Location - City or T | |
| FHear Fire | - 1 | 20a. Method of Disposition 1 V Burial 2 Cremation 3 Re | menual from State | of Disposition (Name of cotory or other place) | | | | |
| no ages ant of int: I | | 4 Donation 5 Other Specify: | //G/il | ford Mem. | Pk 11/1 | L6/06 | Columbia | , MD |
| Baltimore, permit Pages I ar Department of Hes Important: If ite injury or other tr | - 1 | 21. sig_ture of Funeral in tense | 10/2011 | 22. Name and Addres | ss of Facility | WLES F | UNERAL H | ME F.A |
| Baltimo permit Pages Department o Important: | | Lewige N. XI | within . | 246 N. V | Vashingto | on St, F | Rockville | ,MD 20850 |
| Physician | - | 23a. Part I. Enter the isease, or omplication | is that caused the death. Do n | not enter the mode of dying | g, such as cardiac or r | espiratory arrest | , shock, or heart | Approximate Interval |
| /Medical | | failure. List only one cause on each line | | | | | | Between Onset and Death |
| ⁻ xaminer | - 1 | () | ole Stab and Cutting W (or as a consequence of): | /ounas | | | | |
| | | Due to | (or as a consequence or). | | | | | |
| | ᆈ | Sequentially list conditions, if any, leading to immediate Due to | (or as a consequence of): | | | | | |
| | اڃِّ. | cause. Enter Underlying Cause | (8) 80 8 70 10 14 14 11 11 11 11 | | | | | |
| _ | Examiner | (Disease or injury that initiated events resulting in death) Last | (or as a consequence of): | | | | | |
| executed an and al - transit | | d | | | | | | |
| ज ज ल | dical | UNPENDED AME | NDED | | | | | |
| 30x 68760, leath certificate be e attending physici for use as the buri | Jed | IF FEMALE: 23c | If yes, outcome of pregnancy | | | | 23d. Date of delivery | |
| 876 tifica ng ph | ٤ | 001 144 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | Terminal Control | 2 Fetal death 3 | Ectopic pregnand | су | Month Da | y Year |
| x 6 h cer tendii | i Si | 4 | The second of the self- | 5 Other (Specify) | | | | |
| Box 68760 e death certificate be the attending physical for use as the bu | Physician/Med | 1 Yes 2 No 9 Unknown 9 | Unknown | | | | | |
| at the | | Part II. Other significant conditions contri | buting to death but not resulting | ng in the underlying cause | given in Part I. | 23e. Did toba | icco use contribute to th | e cause of death? |
| Division of Vital Records, P.O. tal or Attending Physician: The law requires that the start death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact | by | | | | | 1 Yes | 2 No 3 Proba | bly 4 Unknown |
| ords, w requir ls been s should | Completed | | | | | 24a. Was an | | psy findings available |
| aw nas b | 힐 | | | | | autopsy performe | | mpletion of cause of |
| Rec The cate | 5 | | | _ | | 1 Y Yes 2 | No 1 ✓ Yes | 2 No |
| Vital Rec ysician: The his certificate director, page | Be | 25. Was case referred to medical | | 26.Plac | ce of Death (Check or | ly one) | | |
| Vit. | TO E | examiner? 1 ✓ Yes 2 No | 1:1 Inpatient 2 ER/0 | Outpatient 3 DOA | Other Nursing | Home 5 Re | esidence 6 🗸 Other: | Scene |
| 1 of ling Ph. After t | | 27. Manner of Death 28 | | . Time of Injury 28c. In | | | w injury occurred | |
| ndin th. | 흲 | = 5 Perioling | lov 8, 2006 175 | 59 hrs 1 | Yes 2 V No | ubject stabb | ed and cut | |
| ivision f or Attendi after death. Director: | Certification | 2 Accident Investigation 2 | Be. Place of Injury - At home, | farm, street, factory, office | building, etc. 2 | | eet and Number or Rura | al Route Number, City |
| Div | ŧ | Suicide Could not be determined | Specify) Local Street | | 76 | or Town, Stat 551 Route 1, E | e) Ikridae. MD | |
| Oj ospital hours a uneral i | ပိ | 29a. Certifier | | noth appropriate the time- | | | | d |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri | Medical | ck only Certifying Fifysician: 10 | the best of my knowledge, de e basis of examination and/or | | | | | |
| Vithi Vithi Comp | edi | and n | nanner stated | | | | | 11/ |
| _ / | Σ | 29b. Signature and title of certifier | \wedge | i | nse number | | 29d Date signed (Mont | |
| 5 | | (achaballa | | 0.0 | C.M.E. | | November 9, 2006 | |
| | 1 | name and address person who complete | ted cause of death (Item 23a) | | | | | |
| | J. J | Laron Locke MD. Assistant | Medical Examiner 11 | 11 Penn Street, Balt | timore, MD 2120 | 1 | | |
| 9 | tate | 31. Date filed (Month Pay, Year) 2006 | 32. registrar's Signatur | Angels D | | | | |
| Regis | | MUA T 4 COOD | Denous Kr | Day | | | | |

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) - Day November **Physician** 2006 Chisholm Harrington P^{M} 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 9714 Winery Court Gaithersburg 8. Date of Birth (Month, Day, Year)
Nov. 30,1929 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 1 X F 028-22-5766 76 MÃ Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a, State show a or 28a-f she t be notified a 1 ☐ Yes 2 No MD Gaithersburg Director Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20879 United States 9714 Winery Court 23a Examiner must Funeral items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: ģ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beatrice O'Malley William Chisholm ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4513 Minuteman Drive, Rockville, MD 20853 Kevin Harrington / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. St. Mary s
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition November 13, 2006 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Emitsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility DeVol Funeral Home, 10 Deer Park Drive, Gaithersburg, MD 20877 10 East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Minutes Cardiac Arythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Years Atrial fibrillation Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🖾 No Month 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Hyperlipidemia , Pulmonary fibrosis , Hypertension 1 X Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? 1 ☐ Yes 2 ☐ No perform 2XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3□ DOA 1 🔲 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred o the Hospital or Attending Pithin 24 hours after death.
o the Funeral Director: After the ompletely filled in by the funera Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

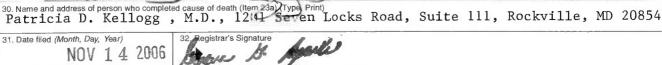
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

31. Date filed (Month, Day, Year) State NOV 14 Registrar

29b. Signature and title of certifier

2006

and manner stated.



29c. License number

D21392

29d. Date signed (Month, Day, Year)

November 10, 2006

| | | 1 | For State Registrar | State of Maryland | d / Depa <i>Cer</i> | rtmen tificate | t of He | ealth and M Death | | iene∠ ig. No. | UUD | 3/913 |
|--------------------------------|---|-----------------|---|---|-----------------------------|--------------------------------------|------------------|--|--------------------------------|------------------|------------------|---------------------------------|
| | | | Decedent's Name (First, Middle, Last) | | | | | | 2. Date of Deat | h | | 3. Time of Death |
| | Physicia | an | Charles | K. Hylton | 1 | | | | Month November | Day c 8 | 2006 | 11:45 A ^M |
| | /Medic | | 4a. Facility Name (If not institution, give s | treet and number) | | 4b. City. | Town, or | Location of Death | 110 1 0 111 0 1 | 1 | unty of Death | |
| | Examin | er | | | | • | kvil | | | Mo | ntgome | rv |
| | | | 320 Broadwood Driv 5. Social Security Number 6. Sex | | st birthday) | If Under | | If Under 24 Hrs. | 8. Date of Birth | | 9. Birth | place (State or Foreign |
| | Funeral Director | | | M 2□F 90 | Yrs. | Months | Days | Hours Min. | July 7 | 1916 | | t Virgin <u>ia</u> |
| | | - | Usual Residence of Decedent | | | | | | oury / | 11710 | , ,,,,,, | C VIIgInia |
| | land | | 10a. State 10b. County | 10c. City | , Town or Lo | cation | | | | | | 10d. Inside City Limits |
| | Many | ō | MD Montgome | rv | | Rock | vi 11e | a | | | | 1 X Yes 2 ☐ No |
| | 288- | Director | 10e. Street and Number | | | 10f. Zip | | | 1 | 0g. Citizen | of What Co | untry? |
| | with Sa or | ā | 628 Monroe Stree | t | | | 20 | 0850 | | U: | nited | States |
| | leath ms 20 | Funeral | 11. Marital Status | 12. Was Decedent Ever in U. | S. 13. V | Vas Deced | ent of His | spanic Origin? (Sp | ecify Yes or No- | 14. | Race - Ame | |
| | fter o | Fun | 1 Never Married 2 Married | Armed Forces? 1 ☐ Yes 2 XNo | | | _ | n, Mexican, Puerto | Hican, etc.) | | Black, White | |
| ğ | al', o | þ | 3 XWidowed 4 ☐ Divorced | If Yes, Give Year or Dates: | 1 | I ☐ Yes | 21XI No | Specify: | | Sp | ecify: | White |
| Ş | 2 ho | Completed | 15. Decedent's Educ | cation | 16a. Deced | lent's Usua | al Occupa | ation during most of work | | | of Business/ | • |
| 2 | nin 7 n n | pie | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4or 5+) | life. L | DO NOT us | se retired, |) | 9 | | onal N cal Ce | |
| 21 | Jiene Piene Trans | E | 8 | | G | lass | Cutt | | | | | licei |
| 힏 | oth of the | Be C | 17. Father's Name (First, Middle, Last) | | | | | 18. Mother's Nam | e (First, Middle, I | Maiden Su | mame) | |
| <u>a</u> | ic av | To B | Paris Hylton | | | | | Et | hel Hear | n | | |
| 2 | 2 should be filed within 72 hours after death with the Maryland and Mental hygiene. Is marked other than "natural", or Itama 23a or 28a-f show aumatic avent, the Medical Examber must be notified at | | 19a. Informant's Name/Relationship (Ty | pe, Print) | 19b. Mailin | ng Address | (Street a | and Number or Rur | ral Route Number | City or To | own, State, Z | Zip Code) |
| Š | nd 2 ilth a 27 is r tra | | Carol Jean Jarnag | in / Daughter | 320 | Broad | dwood | d Drive, | Rockvil1 | le, M | D 2085 | 1 |
| 8 | Hear Ham Itam othe | | 20a. Method of Disposition | 1 0 | ace of Dispo | natory`or c | ther place | -1 | _ | 20c. Locat | ion - City or | Town, State |
| 80 | age: | | 1 XBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) | emoval from State Pari | klawn _P l | Memor | ial | Nove | 2006 | Rock | ville | , MD |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be Department of Health and Menia Important: if item 27 is marked any injury or other traumatic as <u>once.</u> | | 21. Signature of Funeral Service License | | | | | s of Facility | eVol Fur | nera1 | Home. | 10 East |
| B | Dep Imp | | TRACIA H | (11) | | eer 1 | Park | Drive, G | | | | |
| | | | 23a. Part 1. Enter the disease, or compli | cations that caused the death | | | | | | | | Approximate Interval Between |
| | | | shock, or heart failure. List only or Immediate Cause (Final | ne cause on each line. | | | | | | | | Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) | Due to (or as a consequ | tate C | ance | r | | | | | 16 Years |
| | Examiner | | | Due to (or as a consequ | 161106 01). | | | | | | | |
| | | - | Sequentially list conditions, it any leading to immediate cause. Enter Underlying | Due to (or as a consequ | uence of): | | | | | | | |
| | ted | 를 | Cause (Disease of Injury | | | | | | | | | |
| | xecu and | Examiner | that initiated events resulting in death) Last | Due to (or as a consequ | uence of): | | | | | | | |
| 8760, | death certificate be executed e attending physicien and of for use as the burial-transit | dicai E | | | | | | | | | | |
| 687 | icate phys | olbe | | | | | | | | 1717 | | |
| | certil Iding | Ž. | IF FEMALE: 23b. Was decedent pregnant | 3c. If yes, outcome of pregna | | | | | | 230 | d. Date of de | ivery |
| Вох | leath certific attending p I for use as | ciar | in the past 12 months? | 1 Live birth 2 Feta 4 Pregnant at time of d | | ∃Ectopic p ∃Other (s _i | | | | | Month | Day Year |
| 0 | that the de ed by the detached | ysi | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9☐ Unknown | | | | | | | | |
| <u>α</u> | requires that the leen signed by th hould be detache | by Physician/Me | Part II. Other significant conditions con | ntributing to death but not res | ulting in the u | nderlyi n g | cause give | en in Part I. | 23e. Did to | bacco use | contribute to | the cause of death? |
| ds | w requires that s been signed I should be det | | | | | | | | 1 🗆 Y | es 2 🔀 | No 3□Pi | robably 4 Unknown |
| Ď | been | Completed | | | | | | | 24a. Was a | ın I | 24b. Were au | utopsy findings available |
| ĕ | e ta hes je 2 | E D | | | | | | ······································ | autop perfor | sy med? | prior to death? | completion of cause of |
| <u>=</u> | ician: The t certificete he ector, page | | | | | | | | | 2 X No | 1 L Yes | 2 □ No |
| Žį. | Physician: r this certific ral director, | Be | 25. Was case referred to medical examiner? | Hospital: | | | Oth | | th (Check only or | | Lau | ghters Residence |
| of | Phys this at dir | 2 | 1 ☐ Yes 2 No 27. Manner of Death | | ER/Outpatier 28b. Time o | | OA 28c. Injur | | ome 5 Hesid 28d. Describe h | | | (my) Kesidence |
| n n | ing After une | on | 1 XNatural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | Injury | м | Wor | k? Yes 2 ⊡No | | ,, | | |
| Sic | Attending r death. ector: After by the fune | cat | 2 Accident investigation 3 Suicide 6 Could not be | 28e. Place of Injury - At he | ome farm et | | | | 28f. Location (S | treet and I | Vumber or R | ural Route Number, |
| Division of Vital Records, | or Al | Certification: | 4 Homicide determined | building, etc. (Specif | y) | leet, lactor | y, omoo | | City or Tow | | | |
| L | pital urs a srail | | 29a. Certifier 1 X Certifying Phy | sician: To the best of my kno | wledge dest | h occurred | 1 at the tir | me date and place | and due to the | ausa(s) a | nd manner a | s stated. |
| | To the Hospi within 24 hour To the Funer completely fill | ledicai | (Check only 2 Medical Exami | iner: On the basis of examina and manner stated. | tion and/or in | vestigation | n, in my o | pinion, death occu | rred at the time, | date and p | lace, and du | e to the cause(s) |
| | thin (| Mec | 29b. Signature and title of certifier | 4 | | 29 | c. Licens | e number | | 29d. Date | signed (Mon | th, Day, Year) |
| | 1 | | Queson m | Haggerly " | ND | | D.3 | 32407 | | No | vember | 9, 2006 |
| | 6 | | 30. Name and address of person who c | | | Print) | | | | | | |
| | | | Joseph M. Haggert | y, 9707 Medic | al Cer | iter 1 | Drive | e, Rockvi | 11e, MD | 2085 | 4 | |
| | - L | 0.40 | 31. Date filed (Month, Day, Year) | 32. Registrar's Signa | | | 74 | | | | | |
| | St Regist | ate | NOV 142 | 006 | K. A. | rack | D | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Physician 6:15 A_M ANDRIANA HAJICOSTI NOVEMBER 9, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY CASEY HOUSE ROCKVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F 215-62-3649 Director **CYPRUS** 87 DECEMBER 31,1918 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show rthan "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MARYLAND MONTGOMERY SILVER SPRING 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 711 CANNON ROAD 20904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritat Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural any njury or other transmissions." Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No γ Specify: Specify: 3 X Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) SEAMSTRESS SELF EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ MICHAEL SHANOU XENIA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 CANNON ROAD, SILVER SPRING, MARYLAND 20904 XENIA HAJICOSTI - DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN CEMETERY 11/13/2006 SILVER SPRING, MARYLAND 21. Signature of Funeral Sary ice Ligensee HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmm te Cause (Final disease or condition **Physician** BREAST CANCER /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, any, labeling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit the ettending physicien and Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 ANo Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∑Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate hes autopsy performed? 2□ No 1 ☐ Yes 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one, Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how intury occurred Certification: After 1 🕅 Natural 5 Pending investigation М 1 TYes 2 No death after death 2 Accident in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pellij within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) igothic m Dellamo Do H0058032 NOVEMBER 10, 2006

State Registrar

2006 4

CYNTHIA M. WILLIAMS,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Division of Vital Records, P.O. Box 68760,

| | | | | State of Marylan | | partmen <i>ertificat</i> | | | l Mental Hy | rgiene Reg. No.20 | 06 | 3791 |
|-------------------|---|------------------|--|--|----------------------------------|---|--------------------|--------------------------------------|---|---------------------------------|---------------------------|---|
| - | Physicia /Medica | | 1. Decedent's Name (First, Middle, Las JOSEPH E. | HOLT JR. | | | - | | 2. Date of De Month NOV | 10 Day 200 | 6 Yeer | 3. Time of Death 11:12AM |
| | Examine | | 4e Fecility Name (If not institution, give | | | | 4 | lb. City, Town, | or Location of Dea | th 4c. Count | ty of Death | |
| | | | HEARTLAND HEALT | | | | | ADELF | | | P.G. | |
| E | Funeral Director | | 0.0 32 1130 | 744 007 5 | lest birthda 65 Yrs | Months | 1 Year Days | If Under 24 H Hours M | | 1941 | 9. Birth | place (State or Foreign ptry) H. D.C. |
| | and w | - | Usuel Residence of Decedent 10a. Stete 10b. County | 10c. Cit | y, Town or | Location | | | | | | 10d. Inside City Limits |
| | f eho | ō | MD. P.G. | | | PER M | ARL | BORO | | | | ty∑ Yes 2 □ No |
| | h the Marylan r 28e-f ehow | Funeral Director | 10e. Street end Number | | | 10f. Zip | Code | | | 10g. Citizen of | Whet Cou | ntry? |
| | 23e or | <u> </u> | 13016 CLOVERLY | DRIVE | | 2 | 0774 | 1 | | | SA | |
| | iter deat | ner | 11. Marital Status | 12. Was Decedent Ever in U Armed Forces? | ,S. 1 | | | | (Specify Yes or No erto Rican, etc.) | | ce - Americ | |
| 020 | | | 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: | | 1 ☐ Yes | | Specify: | erio nican, etc.) | | ack, White, か:BLA(| |
| 5-0 | n 72 hours "naturel", | je | 15. Decedent's Edu (Specify only highest grad | ication | 16a. De | cedent's Usua | l Occup | ation | varkina | 16b. Kind of E | Business/In | dustry |
| 21215-0020 | | Completed by | Elementary/Secondary (0-12) | College (1-4or 5+) | | | | turing most of w) P WORK | | P | VT. | |
| Maryland | ould be file Mentel Hy arked othy attic event | To Be (| 17. Father's Name (First, Middle, Last) JOSEPH E. HOLT | r SR. | | | | | ame <i>(First, Middle</i> ELL HENI | | me) | |
| | end 2 sho eelth end N n 27 is me her traume | | 19e. Informant's Name/Relationship (7) BARBARA HOLT/W | | 19b. Ma | ailing Address | (Street a | and Number or LY DR. | Rurel Route Numb | er, City or Town | o, State, Zi | MD. |
| Baltimore, | of H of H of H item | | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify, | Removal from State H | lace of Dis | sposition (Nan Rematory or o YY MER | ne of | | Date 11/15/0 | 20c. Location | - City or To | own, State |
| Balti | permit. Peg Depertment important: i any Injury o pnce. | | 21. Signature of Funeral Service Licens | ee | | 22. Name an 3 4 3 5 | | | WATSON N.W. W | F H | | |
| | Physician Medical Examiner | | 23a. Pant1. Enter the disease, or comp shock, or heart failure. List only o immediate Cause (Final disease or condition resulting in death) | AHero | Scl | sequence of): | | andre | o Vascul | ~ J | in | Interval Between Onset and Death |
| 58760, | cete be physicia the bur | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last | o | | sequence of): | | | | | | |
| Box (| es that the deeth certification igned by the attending be detached for use es | by Physician/Me | | J | | | | | | | | |
| P.O. | hat the dead by the detached | Physi | Part II. Other significant conditions con | ntributing to death but not resu | ulting in the | underlying ca | use give | en in Part I. | | | | the cause of deeth' |
| of Vital Records, | aw requir | Completed by | | | | | | | 24a. Was | an autopsy ormed? | ava | ere autopsy findings allable prior to mpletion of cause death? |
| <u> </u> | | 5 | | | | | | | 10 | Yas 2040 | 10 |]Yes 2□ No |
| <u>≅</u> | ysician: The law is certificete hes t director, page 2 s | 20 | 25. Was case referred to medical examiner? | lospitel: | | | Othe | | eath (Check only | | | |
| \subseteq | ng Phy fter this ineral c | 01:00: | 27. Menner of Death 1 ☑Natural 5 ☐ Pending | 28e. Date of Injury (Month, Day Year) | ER/Outpet 28b. Time Injury | ient 3 D0 of 2 / | Bc. Injury Work | 4 V Mursing at ? ∕es 2 □ No | Home 5 ☐ Resi 28d. Describe | dence 6 Oth how injury occur | | 0 |
| Division | To the Hospital or Attending Ph within 24 hours effer deeth. To the Funeral Director: Atter th completely filled in by the funeral | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined | 28e. Place of Injury - At ho building, etc. (Specify | me, farm, | | | | 28f. Location (City or To | Street and Numi wn, Stete) | ber or Rure | il Route Number, |
| - | Hospita 24 hours Funeral etely filler | edical C | 29a. Certifier (Check only one) 1 □ CertifyIng Physical Examination (Check only one) 1 □ Medical Examination (Check only one) | sician: To the best of my knowner: On the basis of examinat and menner steted. | wledge, de ion end/or | ath occurred of investigation, | t the tim | e, date and ple inion, death oc | ce, end due to the curred at the time, | cause(s) and madate and place, | anner as st and due to | ated. the cause(s) |
| | To the Within To the | | 29b. Signature and title of certifier | | | 29c | License | number | | 29d. Date signe | ed (Month, | Day, Year) |
| | | | 1 | MA | | 7 | 0 | 060 | 100 | 11-1 | 4-0 | 6 |
| | Con | | 30. Name end address of person who co | mpleted cause of deeth (Item | 23e) (Tvp | e, Print) | 531 | | | RLVD | 50- | 14 |
| y = | De la | | TAHMINA)C 31. Dete filed (Month, Day, Year) | AltMES | | Sule | no | 27 | Silve | Spring | , n | 16 20903 |
| | State Registra | 5 | NOV 1 5 2006 Bay | 32. Registrar's Signal | de! | | | | | | | |

DHMH 16 Rev 6/95

| | | | 1 - For State Registrar | ate of Maryland / | Depa <i>Cen</i> | rtment of H | ealth and Death | | iene2006 | 37918 |
|----------|---|----------------|--|--|-------------------------|--|--|--|---|-------------------------------------|
| | | | Decedent's Name (First, Middle, Last) | | | | | 2. Date of Deat Month | h Day Year | 3. Time of Death |
| | Physici /Medic | | Eugene DeWitt | Helbig | Sr. | | | Novembe | , | 3:45 P M |
| | Examin | | 4a. Facility Name (If not institution, give street | and number) | | 4b. City, Town, or | Location of Deat | h | 4c. County of Dea | ith |
| | | | 603 Alder Street | | | 0akla | | | Garrett | |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. last b | | If Under 1 Year Months Days | If Under 24 Hrs Hours Min. | (Month, Day, | Year) 9. Bi | rthplace (State or Foreign country) |
| | Director | | 216-22-7435 | 79 | Yrs. | | | Oct. 6, | 1927 Ma | aryland |
| | and * | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Tov | wn or Loc | ation | | | | 10d. Inside City Limits |
| | Maryl f sho | ō | MD Garrett | 0ak | land | | | | | 1√2 Yes 2 No |
| | 28a- | Director | 10e. Street and Number | Oak. | Lanu | 10f. Zip Code | | 10 | Og. Citizen of What C | ountry? |
| | 3a or | Ξ | 602 Aldem Chrock | | | 2155 | 0 | | United St | • |
| | ours after death with the Marylan rai', or items 23a or 28a-f show Exercities must be notified at | Funeral | 603 Alder Street 11. Marital Status 12. W. | as Decedent Ever in U.S. | 13. W | /as Decedent of His Yes, specify Cubar | | pecify Yes or No- | 14. Race - Am | |
| Ω | after or ite | Ē | 1 ☐ Never Married 2 Married 1 | med Forces? ∏Yes 2 ☐ No | | | | o Rican, etc.) | Black, Wh | te, etc. |
| 5-003e | rai', c | l by | | Yes, Give ear or Dates: WWII | 1 | □Yes 2X No | Specify: | | Specify: | White |
| 2 | within 72 hours after death with the Maryland ene. Itan "natural", or items 23a or 28a-f show Ita Medical Examinar must ke motified at | Completed | 15. Decedent's Education (Specify only highest grade com. | | (Give k | ent's Usual Occupa | uring most of wo | rkina | 16b. Kind of Business | s/Industry |
| 7 | ithin | du | | ollege (1-4or 5+) | life. D | O NOT use retired) | • | | | |
| 2 | be filed within 72 hours ital Hygiene. Id other than "natural", event, Ite Medical Exp | ပ္ပ | 12 | | Line | eman | 40.14.1.1.1.1 | | | y Power Co. |
| פעב | | Be | 17. Father's Name (First, Middle, Last) | | | | _ | ne (First, Middle, A | | D 1111. |
| چ | J Mer Dark Dark | P | Robert Emmett | Helbig | 6 44-70- | A | Lorena | | phine | DeWitt |
| Maryland | 12 st th and 7 is n traur | | 19a. Informant's Name/Relationship (Type, Pr | | | | | | City or Town, State, | Zip Code) |
| | s 1 and 2 should f Health and Mer fem 27 is marke other traumatic | | Phyllis Helbig, Wife | 20b. Place of | of Dispos | ition (Name of | Service Street | kland, MD | 21550 20c. Location - City o | r Town, State |
| Itimore, | m O - | | 1X Burial 2 ☐ Cremation 3 ☐ Remov | al from State | ery, crem | atory or other place | 1 | | | |
| | artme artme ortan Injury | | 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee | Oakia | | Cemetery | | 13/2006 | Oakland, rst Funera | |
| n D | permit. Pege Department of Important: if any injury or once. | | * Y a Family VI | 4: T. O | | Traine and Fladres | | | | 1, MD 21550 |
| Ė | | | 23a. Part1. Enter the disease, or complication | s that caused the death. Do | not ente | r the mode of dying | | | | Approximate |
| | Thursinian | | shock, or heart failure. List only one cau Immediate Cause (Final | se on each line. | | 6 1 | , | | | Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) | Due to (or as a consequence | 1 mg | Locyto | c le | elem o | 2 | |
| | Examiner | | | | | ι | | | | |
| Н. | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a consequence | of): | | · · · · · · | | | |
| | be executed iclen and burial-transit | Examiner | Cause (Disease or injury that initiated events | | | | | | | |
| Ď, | e exe len a urial-l | E | resulting in death) Last | Due to (or as a consequence | of): | | | | | |
| 9/6U | ate be executed hysiclen and the burial-transit | licai | d | | | | | | | |
| ٥ | death certificate e attending phys id for use as the | Physician/Med | IF FEMALE: | | | | | | | |
| gog | ath c | lan/ | in the nest 12 months? | yes, outcome of pregnancy Live birth 2 Fetal deat | | Ectopic pregnancy | | | 23d. Date of de Month | livery Day Year |
| | at the de by the a teched t | ysic | 1 Yes 2 No 4 | □Pregnant at time of death □Unknown | 5 □ | Other (specify) | | | | |
| 7. | law requires that the es been signed by th 2 should be deteche | | Part II. Other significant conditions contributi | ng to death but not resulting | in the un- | derlying cause give | n in Part I. | 23e. Did tob | acco use contribute t | o the cause of death? |
| ds, | w requires that been signed b should be dete | d by | | | | , , | | 1 □ Ye | s 2 € No 3 □ P | robably 4 Unknown |
| cora | w req beer shou | Completed | 9. | | | | | 24a. Was ar | 24h Were a | utopsy findings available |
| E E | 9 5 | m d | | | | | | autopsy perform | prior to death? | completion of cause of |
| <u> </u> | sician: Ti certificete irector, pa | e C | 25. Was case referred to medical | | | | 26 Place of De- | 1 ☐ Yes 2 ath (Check only one | | 5 2 No |
| 5 | ysicia s ceri direct | To B | examiner? 1 Yes 2 No Hospita | II: 1 ☐ Inpatient 2 ☐ ER/O | utpatient | 3□ DOA Othe | | | nce 6 ☐Other (Spe | acifu) |
| סר | Attending Physician: r death. sctor: After this certific. by the funeral director, | | 27. Manna of Death 28a | a. Date of Injury 28b. | Time of Injury | 28c. Injury Work | | 28d. Describe ho | | <u>,</u> |
| Ö | Attendir death. ctor: Af y the fur | atic | 2 Accident investigation | (monal, bay roar) | пдогу | | es 2 □ No | | | |
| DIVISION | or Att | Certification: | 3 Suicide 6 Could not be 286 | Place of Injury - At home, f. building, etc. (Specify) | arm, stre | et, factory, office | | 28f. Location (Str City or Town | eet and Number or R State) | ural Route Number, |
| ב | ital o Irs af ral D | | | | | | | | | |
| | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu | edical | (Check only 2 Medical Examiner: O | To the best of my knowledg in the basis of examination a | je, death nd/or inve | occurred at the time estigation, in my op | e, date and place inion, death occu | , and due to the ca irred at the time, da | use(s) and manner a te and place, and du | s stated. e to the cause(s) |
| | To the within 2 To the complet | Mec | 29b. Signature and title of certifier | nd manner stated. | | 29c. License | number | 29 | d. Date signed (Mon | th. Day. Year) |
| | ⊢≱⊢ŏ | | 1 Kin- | 1-72- | l | 10- | 7410 | , | 11/10/1 | 2/ |
| | | _ | 30. Name and address of person who complete | ed cause of death (Item 23a) | (Type - | rint) | - 764 | | 1/15/6 | 21.550 |
| | | 5 | | DOWOS, MD | , (·) po, F | 725 N | Founder | 4 4. | to, oak | |
| B | Sta | te | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature | | Z-J IV. | 10011 | VI) W | ici, cur | u u) IICL |
| | Registr | ar | NUV 13 2006 | Descens B | 6 | and I | | | | |

| | | | For State Registrer | State | of Marylan | • | artment of H tificate of L | ealth and M Death | | ene 2006 | 37919 |
|----------------------------|---|----------------|---|--------------------------------------|--|-----------------------|--|--|----------------------------------|-----------------------------|--|
| | | | Decedent's Name (First, Midd. | le, Last) | | | | | 2. Date of Death | | 3. Time of Death |
| | Physicia | | | Но | ward Les | ter Ha | ines | | Month November | Day Year 11 2006 | |
| | /Medic Examin | | 4a. Facility Name (If not institutio | | | | | Location of Death | | 4c. County of Dea | |
| | LXamin | | 13315 Prices Di | | | | Clar | ksburg | | Monte | gomery |
| | Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In yrs. | last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9 Bi | rthplace (State or Foreign |
| | Director | | 217-36-7643 | 1∭M 2□F | 78 | Yrs. | Months Days | Hours Min. | (Month, Day,) March 17 | 1928 N | ountry) Marvland |
| | | | Usual Residence of Decedent | | | | | | | | |
| | show | | 10a. State 10b. County | ′ | 10c. Cit | ty, Town or Lo | cation | | | | 10d. Inside City Limits |
| | a Ma | tor | Maryland Mon | tgomery | C1a | arksbur | g | | | | 1 □Yes 2 🙀 No |
| | 7 128 | Directo | 10e. Street and Number | | | | 10f. Zip Code | | 109 | g. Citizen of What C | ountry? |
| | 15 wil | | 13315 Prices Di | stillery | Road | | 208 | 71 | | United S | tates |
| | dea Final | Funerai | 11. Marital Status | | ecedent Ever in U Forces? | .S. 13. V | Was Decedent of H | ispanic Origin? (Sp in, Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Race · Am Black, Whi | |
| ٩ | or it | | 1 ☐ Never Married 2 🔀 Mar | rried 1 □ Ye | s 2 No | | 1 ☐ Yes 2 ဩ No | Specify: | | Specify: | |
| 3 | hours after death with the Maryland turel', or Items 23a or 28a-f show al Exacultar must be notified at | d by | 3 Widowed 4 Divorced | d Year o | r Dates: | | | | | | White |
| ភ | 72 h | Completed | 15. Deceder (Specify only highe | nt's Education est grade complete | d) | (Give | dent's Usual Occup kind of work done of DO NOT use retired | during most of work | ing 1 | 6b. Kind of Business | s/Industry |
| <u>.</u> | within 72 ene. than "na ne Mulic | dm | Elementary/Secondary (0-12) | College | e (1-4or 5+) | me. I | | " | | Farmin | ı (r |
| 7 | be filed within 72 hours after death with the Maryla tial Hygiens 2. | | 12 17. Father's Name (First, Middle, | / get) | | | Farmer | 18 Mother's Name | e (First, Middle, Mi | | ٠ ₆ |
| ב | be fi | Be | | | | | | | | 2/30// 55///4///5/ | |
| چ | should bind Ment marked umatic e | ဥ | Walter E. Haine 19a. Informant's Name/Relation | | | 10b Mailin | a Address (Street | Rosie Sm | | City or Town, State, | Zin Code) |
| | 12 st h and 7 le r treur | | Freda A. Haines | | | 1 | | | | | g, MD 20871 |
| | 1 and Health Bm 27 ther tr | | 20a. Method of Disposition | s/ wire | 20b. F | Place of Dispo | sition (Name of | | _ | Oc. Location - City o | |
| چ | Pages nent of I ant: If Its ary or o | | 1 ☑ Burial 2 ☐ Cremation | | m State | cemetery, crer | natory or other plac | | / 2006 I | Emodonials | Maryland |
| ≣ | t. Pa rtmer rtent rjury | | 4 Donation 5 Other (| | Mt | | | | | | , Maryland |
| Baltimore, | permit. Pages 1 and 2 should be filed Depertment of Heating and Mental High Important: If Item 27 le marked other eny Injury or other treumatic event, I once. | | 21. Signature of Funeral Service | D(1/10) | nun | 16 | 521 Oposs | ss of Facility uneral Ho umtown Pi | ke. Fred | erick Mar | yland 21702 |
| | | | 23a. Part1. Enter the disease, o shock, or heart failure. Lis | or complications the | at caused the deat | th. Do not ent | er the mode of dyin | g, such as cardiac | or respiratory arres | st, | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | | / | ance | | | | | Onset and Death |
| | /Medical | | resulting in death) | a. Due | to (or as a consec | | , | 1. / | P (| | () P. 18 - 2 - |
| | Examiner | | Sequentially list conditions, | b | cerebro | Vaso | ular in | 150/t (. | stroke) | | 1 mos. |
| | D # | ner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due | to (or as a consec | quence of): | | | | | |
| | The law requires that the death certificate be executed ite has been signed by the ettending physicien and age 2 should be detached for use as the burial-transit | Examiner | Cause (Disease or injury that initialed events resulting in death) Last | C | | | | | | | |
| Ö, | e exe ien a urial- | ũ | resulting in death) cast | Due | to (or as a conseq | quence or): | | | | | |
| 8760, | ate b hysic the b | dicai | | d | | | | | | | |
| 9 | eath certific ettending p | | IF FEMALE: | | | | | | | | |
| Вох | eath cert ettendin for use | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | 1 ☐Liv | outcome of pregnate birth 2 Feta | aldeath 3 | Ectopic pregnancy | , | | 23d. Date of de Month | elivery Day Year |
| o. | the edf | sici | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | | egnant at time of o iknown | death 5 | Other (specify) | | | | |
| <u>ď</u> | res that the designed by the e | Ph) | Part II. Other significant condit | ione contribution t | a death but not res | culting in the u | aderhijaa cause aiv | on in Part I | 23e Did toba | acco use contribute | to the cause of death? |
| Ś | ires ti signe d be c | by | | . //./. | 7 7 | solding in the b | riderlying cause giv | on an i gara. | 1 □ Yes | | Probably 4 Unknown |
| 5 | w requir been s should | stec | Covanon | 1 HOVEN | 7 1150 | 050 | | | | - | |
| ခ | elaw has b | Completed | | | | | | | 24a. Was an autopsy perform | prior to | autopsy findings available completion of cause of |
| = | | S | | | | | | | | PNo 1 □ Ye | |
| ij | Attending Physician: r death. ector: After this certificaby the funeral director. | Be | 25. Was case referred to medic examiner? | | | | Oth | 00 | h (Check only one | | |
| 5 | hysi this c | ၉ | 1 Yes 2 No | | | ER/Outpatier | | 4 Nuising no | | nce 6 Other (Sp | ecify) |
| Ĕ | ing f | Ö | 27. Manner of Death 1 ■ Natural 5 ■ Pend | "'9 | ate of Injury fonth, Day Year) | 28b. Time o Injury | Wor | | 28d. Describe how | w injury occurred | |
| . <u>s</u> | tend death tor: / | cat | 2 Accident inves 3 Suicide 6 Could | tigation | Alabas Ath | | | Yes 2 □ No | 29f Location /Str | ant and Number or I | Rural Route Number, |
| Division of Vital Records, | To the Hospital or Attending Ph within 24 hours eiter death. To the Funeral Director: After the completely filled in by the funeral | Certification; | | missed 288. Pl | ace of Injury - At h uilding, etc. (Speci | fy) | reet, raciory, onice | | City or Town, | | nural moute Number, |
| _ | Hospital or 24 hours efte Funeral Dir tely filled in | | 29a. Certifier 1 Certify | ina Physicien: To | the best of my kno | owledge, deat | h occurred at the tir | ne, date and place, | and due to the car | use(s) and manner a | as stated. |
| | • Ho: 124 h • Fur letely | edical | (Check only 2 Medica one) | | e basis of examina nanner stated. | ation and/or in | vestigation, in my o | pinion, death occur | red at the time, da | te and place, and de | ue to the cause(s) |
| | To the Ho within 24 To the Fu completed | Me | 29b. Signature and little of pertific | ier | × | | 29c. Licens | | | d. Date signed (Mgr | |
| | | | 1 | 5 | | | H58 | 132 V | 1D | 11/13/0 | 06 |
| 1 | Ó | | 30. Name and address of person | n who completed o | ause of death (Item | m 23a) (Type, | Print) | | | | |
| 1, | J | | Dr. Benjamin | F. Papoi. | P. C. 9 | 815 Ma | in Street | . Suite | 1.Damasc | us MD 208 | 72 |
| | Sta | ate | 31. Date filed (Month, Day, Yea | 1 2006 3 | 2. Registrar's Sign | ature | land. | | , | | |
| | Regist | rar | NUV 1 | 4 2006 | HELLIN. | 15 19 | | | | | |

| | | | For | State of Maryland | / Department of Health and | Mental Hyg | giene | 27020 |
|-------------------|---|------------------|---|--|---|--|--|--|
| | | | State Registrar Decedent's Name (First, Middle, La | st) | Certificate of Death | 2. Date of Dea | | 3. Time of Death |
| | Physici /Medic | | NATHANIEL | - HAMILT | ON | Month | Day Yeer D7 06 | 1930 M |
| | Examin | | 4a. Facility Name (If not institution, give | e street and number) | 4b. City, Town, or Location of Dea | th | 4c. County of Death | 7 |
| | Funeral | | 5. Social Security Number 6. S | | | | PRIVE 9. Birthy | place (State or Foreign |
| | Director | | 216-10-8018 | 19th 20 F 54 | Yrs. Months Days Hours Mir | July 1 | | INGTON DC |
| | /land | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, 1 | Town or Location | | | 10d. Inside City Limits |
| | 72 hours after deeth with the Maryland natural', or Itama 23a or 28a-f ahow issal Examinar must be notilised at | Funeral Director | MARY IANG PRINCE | Georges lipp | CR MARIBORO | | 10g. Citizen of What Cou | 1 ☑ Yes 2 ☐ No |
| | th with | al'Di | 11591 Chalter | ham Boad | 20772 | | 4317 | |
| | er dee Itama | uner | 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue | Specify Yes or No- rto Rican, etc.) | 14. Race - Ameri Black, White, | |
| 036 | urs aft | by | 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☐ No Specity: | | Specify: B | ack |
| 21215-0036 | 72 hours "natural" | Completed | 15. Decedent's E (Specify only highest gr | ducation ade completed) | 16a. Decedent's Usuat Occupation (Give kind of work done during most of w | orking | 16b. Kind of Business/In | dustry |
| 121 | within iene. than | ompi | Elementary/Secondary (0-12) | College (1-4or 5+) | MAIN LUNANCE | | Doundal | Ashalt |
| | I Hygi other | Be Co | 17 Father's Name (First, Middle, Last | | | me (First, Middle, | Maiden Sumame) | - i |
| ylar | should be nd Mental marked o | To E | Chaelas E | 14, | amilton Se. Ellan | 1 | | -ord |
| Maryland | s 1 end 2 should F Health and Mer Itam 27 ia marke other traumatic | | 19a. Informant's Name/Relationship | Type, Print) | 19b. Mailing Address (Street and Number or F | 11 | r, City or Town, State, Zip | Code) |
| | s 1 en f Heal itam 2 other | | 20a. Method of Disposition | 000 | ce of Disposition (Name of netery, crematory or other place) | Date | 20c. Location - City or To | own, State |
| Baltimore, | 0 0 | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci | Hemoval from State | surrection 11- | 15-266 | Clinton N | (ARY/AND |
| 3alt | permit. Pag Depertment Important: I any Injury o | | 21. Signature of uneral/Service trice | | 22. Name and Address of Facility | Ams Ful | WEEAL Hom. | 1 |
| | 40364 | 3 3 | 23a. Part1. Enter the disease, or con- | plications that caused the death. | Do not enter the mode of dying, such as cardia | nd Houn | | NC20608 Approximate |
| | Pnysician | | shock, or heart failure. List only Immediate Cause (Finat | one cause on each line. | | | L IN FARCTION | Interval Between Onset and Death |
| 4 | /Medical | | disease or condition resulting in death) | Due to (or as a consequen | | | J. (1.1.6). | |
| | Examiner | ē | Sequentially list conditions. | b. Due to (or as a consequen | nes off | | | |
| | uted d ansit | Examine | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | , | nee ory. | | | |
| 0, | ate be executed hysicien and the burial-transit | | resulting in death) Last | c. Due to (or as a consequent | nce of): | | | |
| 68760 | icate be physici s the bu | dical | | " d | | | | |
| Box 6 | leath certific attending p | √Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregnance | y _ N | IA | 23d. Date of delive | ery |
| Э. В | death he atte | Physician/Med | in the past 12 months? 1 ☐ Yes 2 ☑ Ho | 1 Live birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown | eath 3 Lectopic pregnancy | | Month | Day Year |
| P.O. | Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be deteched for use as the burial-transit | | 9 ☐ Unknown Part If. Other significant conditions | | ng in the underlying cause given in Part I. | 23e. Did to | bacco use contribute to t | ne cause of death? |
| of Vital Records, | quires en sign | ed by | | MELLITUS | | 1 🗆 Y | res 2 □ No 3 □ Prob | pably 4 Whiknown |
| eco | e law requ has been je 2 shoul | Completed | PERIPHERAL | VASCULAR I | DISEASE | 24a. Was a | an 24b. Were auto | psy findings available mptetion of cause of |
| <u>=</u> | : The l cate ha | Соп | | | | perfor | med? death? 2☐NO 1☐Yes | 2□ No |
| Vita | sician: Th certificate irector, pag | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | SOUTHERN MARY Hospitat: 1 Impatient 2 PEF | Other | ath (Check only or | ne) ence 6 Other (Specif | |
| اه ر | ig Phys ter this neral di | H- 1 | 27. Manner of Death | | 8b. Time of thiury at Work? | T | ow injury occurred | y) |
| sior | Attending or death. | catio | 1 ☐Maturat 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not the | n | M 1 Yes 2 No | | | |
| - | 2 # - C | Certification: | 3 Suicide 6 Could not to determined | | e, farm, street, factory, office | 28f. Location (S City or Tow | treet and Number or Rura n, State) | al Route Number, |
| | To the Hospital of within 24 hours af To the Funeral D completely filled in | | (Check only 2 Medical Exa | ninar: On the basis of examination | edge, death occurred at the time, date and place in and/or investigation, in my opinion, death occ | e, and due to the c curred at the time, c | cause(s) and manner as s late and place, and due to | tated. |
| | o the lithin 2 o the lo | Medical | one) 29b. Signature and title of certifier | and manner stated. | 29c. License number | | 29d. Date signed (Month, | |
| | F 5 → 5 | |) m | MD | MD005780 | | 11/8/06 | |
| 1 | 3.3 | | 30. Name and address of person who MUHAMMAD AS | completed cause of death (Item 2 HRAF 5711 SAR | 3a) (Type, Print) RVLS AVE, SUITE 100 RI | VERDALE | MD 2073 | 7 |
| | Sta Registr | | 31. Date fited (Month, Day, Year) | 32. Redistrar's Signatur | & Sperke | | | , |

| | | | | For State | State of | Maryland / D | - | nent of H | | - | 00 | nc | 27021 |
|-------------|------------|--|----------------|---|---------------------------|---|---------------------------|-----------------------------------|---------------------------------|---------------------------------|------------------|-------------------|--|
| | | | | Registrar 1. Decedent's Name (First, Middle, Las | !) | | Jerum | cate of i | Dealli | 2. Date of De | | <u>U6</u> | 3. Time of Death |
| | I. | Physici | | CHARLES | , ј. | | HICK | MAN | | Month NOV. | Day | Year 2006 | 10:43 A ^M |
| | 10 | /Medic Examir | | 4a. Facility Name (If not institution, give | | ber) | | | Location of Death | 110 11 | 4c. Count | | 10.45 A |
| ~ | | | | ATLANTIC GENERA | L HOSPI | ΓAL | | BERL | IN | | WC | RCEST | TER . |
| Fe | | Funeral | | 5. Social Security Number 6. Se | X M 2 F | 7. Age (In yrs. last birth | Mo | Inder 1 Year onths Days | If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da | th y, Year) | 9. Birthp | place (State or Foreign |
| 200 | | Director | | Usual Residence of Decedent | | 71 Y | rs. | | | APR. 21 | , 1935 | DEI | LÁWARE |
| = 1 | | land ow | | 10a. State 10b. County | | 10c. City, Town | or Location | n | | | | 1 | 0d. Inside City Limits |
| = 0 | | death with the Maryland ms 23s or 28a-f show | to | DELAWARE SUSSEX | | SELBY | VTI.I.F | ī. | | | | | 1 X Yes 2 □ No |
| 00 | | th the | Director | 10e. Street and Number | | 32221 | 1 | f. Zip Code | ··· | | 10g. Citizen of | What Cour | ntry? |
| 90 | | 23£ c | aiD | 60 LIGHTHOUSE R | DAD | | | 1997. | 5 | | USA | • | |
| ~ [| | after dea | Funerai | 11. Marital Status | Armed Ford | | 13. Was [If Yes | ecedent of Hi | ispanic Origin? (Spanic Origin) | ecify Yes or No Rican, etc.) | - 14. Rac | ce - Americ | |
| | 36 | filed within 72 hours after Hygiene. ither than "natural", or Ite ant, Ite Medicel Exterior | by Fi | 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced | 1 X Yes 2 If Yes, Give | 2 □ No les: 1956 – 59 | | es 2 No | Specify: | . , | Specil | | |
| 2 | 2-003 | 72 hours "natural", | | 15. Decedent's Edi | | | Decedent's | Usual Occupa | ation | | 16b. Kind of B | WILL | |
| is | 215 | nin 72 nin nin | piet | (Specify only highest grade Elementary/Secondary (0-12) | (1-College (1- | | Give kind o life. DO N | of work done of OT use retired | during most of work | ing | TOD. KING OF D | 03111633/1116 | oustry |
| 5 | 21 | d with | Completed | 12 | College (1- | 401 34) | CON | TRACTO | ? | | CONS | TRUCT | CION |
| 7 | pu | be file tal Hy d oth | Be (| 17. Father's Name (First, Middle, Last) | | | | | 18. Mother's Name | e (First, Middle, | Maiden Sumar | n <i>e)</i> | |
| 4121119 | Maryland | s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. I health and Sac or 28a-1 show item 27 is marked other than "natural", or Items 23s or 28a-1 show other traumatic event, if a Madical Extention of the traumatic event, if a Madical Extention of the standard of the second of t | 70 | ANDREW M. | | HICKMAN | | | LAURA | | СНАМВ | | |
| | Mar | 12 sh h and 7 is n traum | | 19a. Informant's Name/Relationship (T) | | | | | and Number or Rura | | | | |
| 06 | | s 1 and 2 f Health item 27 i | | GAIL M. HICKMAN | WIFE | 20b. Place of I | | | ROAD, SE | LBYVILL | E, DE. | | |
| 0 | Baltimore, | Pages nent of I ant: If itu | | 1X Burial 2 ☐ Cremation 3 ☐ F | | tate cemetery | , crematory | or other plac | θ) | | | , | |
| \supset | Ē | 그는 본 등 | | 4 □ Donation 5 □ Other (Specify,21. Signature of unital Service Licens | 1 | KEDMEI | - | EMETERY | | 5/06 | SELBYV | LLLE, | DELAWARE |
| | Ba | permit Depar Impor any ir | | 11/10 las | 2/5 | 1 | | | JNERAL HO | ME. SEL | BYVILLE | DE. | 19975 |
| 2 | | | | 23a. Part. Enter the disease, or comp shock, or heart failure. List only o | lications that ca | used the death. Do no | | | | | | , | Approximate |
| 5 | | Physician | | Immediate Cause (Final disease or condition | ne cause on ea | err line. | | S1. | 1- | | | | Interval Between Onset and Death |
| 0 | | /Medical | 3 | resulting in death) | Due to (o | r as a consequence of |): | 3000 | | | | | |
| + | | Examiner | | Sequentially list conditions | Ac | r as a consequence of | 140 | card | int in | Fanci | ties | | |
| 7 | | pe ii | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (o | r as a consequence of |): 🕙 | | | | | | |
| 1 | | ecute and I-trans | каш | that initiated events resulting in death) Last | c. Due to (o | r as a consequence of | ١. | | | | | | |
| 77 | 8760, | cate be executed physician and the burial-transit | | | Due to (o | i as a consequence of |). | | | | | - 10 | |
| ,7 | 687 | cate phy: | edicai | | d | | | | | | | | |
| 5 | XO | death certifi e attending id for use as | n/M | IF FEMALE: 23b. Was decedent pregnant | | ome of pregnancy | | | | | 23d. Da | te of delive | rv |
| 2 | m. | 0 0 0 | Physician/Me | in the past 12 months? 1 ☐ Yes 2 🗷 No | 4☐ Pregna | th 2 Tetal death nt at time of death | | oic pregnancy or (specify) | | | | | Day Year |
| 7 | 0. | at the de by the tached | hys | 9 ☐ Unknown | 9□ Unknov | ٧n | | | | | | | |
| \geq | S, | The law requires that the ste has been signed by the bage 2 should be detache | by F | Part II. Other significant conditions co | | _ | he underly | ing cause give | n in Part I. | 23e. Did to | bacco use cont | ribute to th | e cause of death? |
| (| ord | w requir been si should | ted | | Metal | e M | | | | 1 🗆 Y | ′es 2□No | 3 Proba | ably 4 Unknown |
| _ | ec | e law r has be pe 2 sh | ompieted | Hypentens | csh. | | | | | 24a. Was autop | an 24b. | Were autop | osy findings available inpletion of cause of |
| 7 | E H | | Co | <u>'</u> | | | | | | perfor 1 ☐ Yes | | death? I 🗌 Yes | 2□ No |
| \emptyset | Vita | sician: Th certificate rector, pag | Be | 25. Was case referred to medical examiner? | lospital: | | | Otho | 26. Place of Death | (Check only o | ne) | | |
| 5 | of | Phys r this ral dii | : To | 1 Yes No | 1 □ Inj | Injury 28b. Tir | | DOA Othe | 4 Littershing Flor | | ence 6 Oth | |) |
| 2 | O | th. th. : After funer | tion | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation | | Day Year) Inj | | Work | ?` 'es 2 □ No | zad. Describe ii | ow injury occur | 90 | |
| 5 | Division | Attending Physician: or death. sctor: After this certific by the funeral director. | ifica | 3 Suicide 6 Could not be | 28e. Place o | f Injury - At home, fam | n, street, fa | | | | | er or Rural | Route Number, |
| 土 | ā | in Sign | Certification: | 4 Homicide determined | building | g, etc. (Specify) | | | | City or Tow | n, State) | | |
| | | Hospital Hospital Mours S Funeral Hely filled | | 29a. Certifier Check only 2 Medical Exami | sician: To the b | est of my knowledge, | death occu | rred at the tim | e, date and place, a | and due to the o | ause(s) and ma | nner as sta | ated. |
| | | the in 2 the | Aedicai | one) | and manne | is of examination and/ r stated. | or mivestiga | | | | | | |
| | | Vith Vith Con | Σ | 29b. Signature and title of certifier | 10 | | | 29c. License | number | 1 | 29d. Date signed | d (Month, E | Day, Year) |
| | | 08 | | 1/1/2 | 4 | n/) | | 0) | 24/10 | 0 | 11/1 | 2/6 | 06 |
| | 1 | 7872 | 9 | 30. Name and address of person who co | empleted cause | of death (Item 23a) (T | pe, Print) | 12 0 | <i>—</i> 1 | 0 - | 11 | 10. | n:s |
| | | Sta | te | 31. Date filed (Month, Day, Year) | 21 (9 nd) | or death (Item 23a) (19 - 314 Fir gistrar's Signature | rinkl | IN HUE | 2, Juite 4 | us wer | $u_h, 7h$ | الخي، إ | 2() |
| | | Registr | - | NOV 142 | | 4 | 1 | <i>u</i> . | | | | | |

| | | | for State Registrar | State of Ma | ryland | | rtment of H | | d Men | | iene 0 | 06 | 37922 |
|--------------|--|------------------|--|---|--------------------------|--------------------------------|---|--------------------------------------|----------------------|---|-----------------------------|--------------------------------------|--|
| | Physici | | 1. Decedent's Name (First, Middle, Last) | Hu | 250 | n | - | - | | Date of Deat Month | - | Year 06 | 3. Time of Death OHSA M |
| jk | /Medic Examin | | 4a. Facility Name (If not institution, give s | treet and number) | Lay | Le | 4b. City, Town, or | Location of De | eath | | 4c. Count | y of Death | Mico |
| | Funeral Director | | 5. Social Security Number 6. Sex 220-12-0941 Usual Residence of Decedent | M 2FSFE | (In yrs. last B2 | | Months Days | If Under 24 H Hours M | lin. (/ | Date of Birth Month, Day, 2/18/1 | Year) | Coun | place (State or Foreign ntry) 'Ginia |
| | Maryland -f ehow | tor | 10a. State 10b. County Maryland Worcest | | - | now H | | | | | | 1 | 0d. Inside City Limits 1 ☐ Yes 2 🎛 No |
| | h with the | Funeral Director | 10e. Street and Number 3736 Nassawango Hil | | | | 10f. Zip Code 218 | 363 | | 1 | 0g. Citizen of USA | | ntry? |
| 036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If term 27 is marked other than "naturel" or Items 23a or 28a-f show important: If term 27 is marked other than "naturel" or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once. | þ | 11. Marital Status 1 Never Married 2 Married 3 🖾 Widowed 4 Divorced | 2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | | | as Decedent of Hi Yes, specify Cuba | | (Specify lento Ricar | Yes or No- n, etc.) | | ce - Americ ack, White, fy: Wh | |
| 21215-0036 | l within 72 ho lene. r than "natur ihe Med cal | Completed | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) | | | (Give k. life. Di | nt's Usual Occupa ind of work done of ONOT use retired aty Clerk | during most of v) | working | | 16b. Kind of E State | | |
| land 2 | ild be filed ental Hyg ked other Ic event, | To Be C | 17. Father's Name (First, Middle, Last) Royal S. Widgeon | | | ЭСР | 0101 | 18. Mother's N Mary | | st, Middle, A | | | rmerre |
| Maryland | nd 2 shou ath and M 27 is mar | | 19a. Informant's Name/Relationship (Typ. Mary H. Bradley/d | | | - | Address (Street a | | | | | | |
| Baltimore, | Pages 1 a lent of Hea nt: If Item ry or othe | | 20a. Method of Disposition 1 □ Burial 2 ③Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) | emoval from State | cem | etery, crema | tion (Name of atory or other place Cremato: | | Date /9/06 | | 20c. Location Salish | | |
| Balti | permit. Departmitmporta eny inju | | 4 Donation 5 Other (Specify) Salisbury Crematory 11/9/06 21. Signature of Funeral Service Licensie Holloway Funeral Home I 501 Snow Hill Rd., Sali | | | | | | | | | | |
| | Physician /Medical Examiner | | 23a. Part. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) | e cause on each line Due to (or as a | tic (| Cauer | the mode of dying. | | | / | rım | 0 | Approximate Interval Between Onset and Death |
| 8760, | ate be executed hysician and the burial-transit | dical Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a | | | | | | | | | |
| P.O. Box 687 | ne death certific the attending pl hed for use as t | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) \(Ye | 3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown | Fetal de | ath 3 🗆 E | ctopic pregnancy Other (specify) | | | | | ate of delive | ery Day Year |
| rds, P. | quires that the signed by all did be detacted | Ď | Part II. Other significant conditions con | tributing to death but | not resultin | ng in the unc | derlying cause give | en in Part I. | | 23e. Did tob | 1 | tribute to th | ne cause of death? |
| | | Completed | | | | | | | - | 24a. Was ar autops perform 1 □ Yes 2 | y | prior to con death? | psy findings available inpletion of cause of |
| Zita Zita | ysician: T | Be c | 25. Was case referred to medical examiner? 1 Yes 2 No | ospital: | 0050 | | 3□ DOA Othe | 26. Place of D | | | | | |
| ion of | ding Pt h. After th funeral | ation; To | 27 Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Cate of Injury (Month, Day | 28 | Outpatient Bb. Time of Injury | 28c. Injury Work | 4 Nursing | | | nce 6 ⊡Oti w injury occu | | Y) |
| Divis | in Life | Certification; | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury building, etc. | y - At home (Specify) | , farm, stree | et, factory, office | | | ocation (Str City or Town | | ber or Rura | l Route Number, |
| | the Hospital or hin 24 hours afte the Funsral Dir npletely filled in | edicai | 29a. Certifier Certifying Phys | ician: To the best of er: On the basis of e and manner state | xamination | edge, death of and/or inve | occurred at the time stigation, in my op | ne, date and pla pinion, death oc | ace, and c | due to the ca the time, da | use(s) and mate and place, | anner as st and due to | ated. the cause(s) |
|) | To the Hospital within 24 hours a To the Funsral (| Med | 29b. Signature and title of certifier | 11 | Turk | <u> </u> | 29c. License | | 70 | | 9d. Date signe | | |
| | 192 | | 30. Name and address of person who con | mpleted cause of dea | 1 11- | Ba) (Type, P | rint) | 04 177 | 18 | Sala | .)_ ^ | w | 21802 |
| * | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 1 3 20 | 32. Aggistrar | | | 20 % 0 | -/~ | J | Jarris | 0' |) | <i>y</i> - <i>c</i> y |

DHMH 17 Rev 1/2001

ORIGINAL

| /Medic | an | 1. Decedent's Name (First, Mide Lottie | dle, Last) Morris | | Hear | tificate of | | 2. Date of Month | | Day 2006 | 3. Time of Death a 8:40 M |
|--|--|--|--|--|--|--|---|--|---|---|--|
| | al | 4a. Facility Name (If not instituti | | ber) | near | 4b. City, Town, | or Location o | | | 4c. County of Death | 0.40 |
| Exam. | CI | 9360 Green Bra | | | | Willa | | | | Wicomic | |
| Funeral Director | | 5. Social Security Number 214-10-6400 Usual Residence of Decedent | 6. Sex 1 ☐ M 25€ F | '. Age (In yrs. last 87 | birthday) Yrs. | If Under 1 Year Months Days | | Min. 8. Date of Mont. 4/2/ | 1919 | 9. Birthi Cou Mary | place (State or Foreign ntry) Land |
| Now W | | 10a. State 10b. Coun | ty | 10c. City, To | own or Lo | cation | | | - | | 10d. Inside City Limits |
| Sa-fal | ctor | | comico | | Salis | | | | | | 1X Yes 2 No |
| e or 2 | Funeral Director | 10e. Street and Number 510 Douglas Ro | nad. | | | 10f. Zip Code 218 | 201 | | 10g. | Citizen of What Cou USA | ntry? |
| ms 23 | nera | 11. Marital Status | | dent Ever in U.S. | 13. \ | | | gin? (Specify Yes , Puerto Rican, etc | or No- | 14. Race - Ameri Bleck, White, | |
| Within 72 hours after death with the Maryland iene. Then *naturel*, or Items 23e or 28e-f show the Madical Examiner must be notified at | ρ | 1 Never Married 2 Ma 3 XWidowed 4 Divorce | arried 1 Tes | 2[X No | | Yes 2 No | | , r dono rnozn, de | ., | | nite |
| 8 4 | eted | 15. Decede (Specify only high | ent's Education rest grade completed) | 11 | (Give | lent's Usual Occu kind of work done OO NOT use retire | during mos | t of working | 16b | . Kind of Business/Ir | dustry |
| ill Hygiene. other then " | Completed | Elementary/Secondary (0-12) |) College (1- | 4or 5+) | | er/operat | | | L | ingerie & | Fabric |
| I Hyg othe | BeC | 17. Father's Name (First, Middle | e, Last) | | | | | er's Name (First, M | | | |
| should by | Tof | Robert Stanle | | | | | | nnie Gord | | | . 0. 1.1 |
| 2 6 7 6 7 | | 19a. Informant's Name/Relation Kaye Frances I | | 1 | | | | Salisbury | | ty or Town, State, Zij 21801 | o Code) |
| s 1 and if Health Item 27 other tr | | 20a. Method of Disposition | | 20b. Place | | sition (Name of natory or other pla | | Date | - | . Location - City or To | own, State |
| Pages ment of ant: If It ury or o | | 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other | | iate | | y Cremat | 1 | 11/8/06 | | Salisbury | MD |
| permit. Pag Department Important: I any injury c | | 21. Safatore of Funerar Service | ce Censee | | 12 5 | olloway Ol Snow | Funer Hill | ăl Home H Rd., Sali | rofe | ssional As y, MD 2180 | ssociation)4 |
| | | 239 Part 1. Enter the disease, spock, or heart failure. Li | ist only one cause on ea | ich Ine | | n | | cardiac or respirat | | | Approximate Interval Between Onset and Death |
| re be executed was special and was special and was special transit and special transit and special and special transit and spe | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or a jury that initiated events resulting in death) Last | C | or as a consequen | ce of): | | | | | | |
| | call | , | d | or as a consoquen | ce of): | | | | | | |
| 9 % 9 | ical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | d | come of pregnancy rth 2 Fetal de | vath 3 | Ectopic pregnan | су | | | 23d. Date of deliv Month | ery Day Year |
| 9 % 9 | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No | d | come of pregnancy rth 2 Fetal de ant at time of death wn | nath 3 | Other (specify) | | . 23e. | Did tobace | | Day Year he cause of death? |
| 9 % 9 | by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | d | come of pregnancy rth 2 Fetal de ant at time of death wn | nath 3 | Other (specify) | | . 23e. | Did tobacc | Month co use contribute to t | Day Year he cause of death? |
| The law requires that the death certificate are has been signed by the attending phy: page 2 should be detached for use as the | by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | d | come of pregnancy rth 2 Fetal de ant at time of death wn | nath 3 | Other (specify) | | | 1 ☐ Yes Was an autopsy performed | Month co use contribute to to 2 \(\text{No} \) 3 \(\text{Pro} \) Pro | Day Year he cause of death? bably 4 Junknow |
| The law requires that the death certificate are has been signed by the attending phy: page 2 should be detached for use as the | Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant cond D. C. L. L. L. L. L. L. L. L. L. L. L. L. L. | d. 23c. If yes, outding the pregnage of the pr | come of pregnancy rth 2 Fetal de at time of death wn ath but not resultin | / wath 3 ⊡ h 5 ⊡ | Other (specify) | 26. Place | 24a. | 1 Yes Was an autopsy performed /es 2 7 | Month co use contribute to 12 No 3 Pro 24b. Were autriprior to codeath? No 1 Yes | he cause of death? bably 4 Unknown psy findings availably mpletion of cause of |
| Physicien: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the | To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant cond D. Color C. FCP D. C. C. FCP 25. Was case referred to mediexaminer? 1 Yes 2 No 27. Manner of Death | d | come of pregnancy th 2 Fetal de ant at time of death wn ath but not resultin | /aath 3 in the ui | other (specify) | 26. Place then: 4 Nu | 24a. 1 O of Death (Check sursing Home 5 | 1 ☐ Yes Was an autopsy performed (es 2 ☐ poly spe) | Month co use contribute to to 2 \(\text{No} \) 3 \(\text{Pro} \) Pro | he cause of death? bably 4 Junknow psy findings availab mpletion of cause of |
| ding Physicien: The law requires that the death certificate h. | To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant cond D. C. C. C. C. C. C. C. C. C. C. C. C. C. | d. 23c. If yes, outded to the program of the progra | come of pregnancy rith 2 Fetal de ant at time of death wn ath but not resultin | h 3 h | other (specify) anderlying cause g | 26. Place | 24a. 1 O of Death (Check ursing Home 5 D 28d. D 1 | 1 ☐ Yes Was an autopsy performed (es 2 ☐ poly spe) | Month co use contribute to 12 No 3 Pro 24b. Were autriprior to co death? No 1 Yes 6 La ther (Special | he cause of death? bably 4 Junknow psy findings availably physical properties of the cause of |
| or Attending Physicien: The law requires that the death certificate for deceath. Ifter deceath. Iftector: Attentis certificate has been signed by the attending physiciector. Page 2 should be detached for use as the next page 2. | To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant cond D. C. C. F. F. C. C. F. C. C. C. C. C. C. C. C. C. C. C. C. C. | d. 23c. If yes, outding to de with the call Hospital: 1 It It It It It It It | come of pregnancy th 2 Fetal de ant at time of death wn ath but not resultin | / ath 3 in the unit of the uni | other (specify) nderlying cause g at 3 DOA 28c. Inj W M 1[| 26. Place ther: 4 Nury at ork? | 24a. 1 1 2 9 of Death (Check arsing Home 5 2 28d. D | Was an autopsy performed (es. 2.2) only spe) | Month co use contribute to to 2 No 3 Pro 24b. Were autroprior to codeath? No 1 Yes 6 Lether (Specification occurred) t and Number or Run | he cause of death? bably 4 Junknown posy findings availably mpletion of cause of 2 No |
| or Attending Physicien: The law requires that the death certificate for deceath. Ifter deceath. Iftector: Attentis certificate has been signed by the attending physiciector. Page 2 should be detached for use as the next of the funeral director, page 2 should be detached for use as the | Certification: To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant cond D. C. C. F. P. 25. Was case referred to mediexaminer? 1 Yes 2 No 27. Manner of Death Natural 5 Peninded Peninded Peninded 3 Suicide 6 Could Gete 29a. Certifier 1 Certifier 29b. Was decedent 1 Certifier 29c. Certifier 1 Certifier 29c. Verifier 1 Certifier 29c. Verifier 1 Certifier 29c. Verifier 1 Certifier 29c. Verifier 1 Certifier 29c. Verifier 1 Certifier 29c. Verifier 1 Certifier 29c. Verifier 1 Certifier 29c. Verifier 1 Certifier 29c. Verifier 1 Certifier 29c. Verifier 1 Certifier 29c. Verifier 1 Certifier 29c. Verifier 1 Certifier 29c. Verifier 1 Certifier 29c. Verifier 1 Certifier 29c. Verifier 1 Certifier 29c. Verifier 1 Certifier 29c. Verifier | d. 23c. If yes, outding to de with the call Hospital: 1 It It It It It It It | come of pregnancy th 2 Fetal de- ant at time of death wn ath but not resultin patient 2 ER. if Injury h, Day Year) 28 of Injury - At home g, etc. (Specify) best of my knowle- lisis of examination | /ath 3 h 5 ming in the unit of | other (specify) at 3 DOA 28c. Inp. M 1[eet, factory, office | 26. Place ther: 4 Nury at ork? Yes 2 | 24a. 1 O of Death (Check arsing Home 5 Death (C | 1 ☐ Yes Was an autopsy performed (*e's 2 ☑ *) In Signal (*e's autopsy) In Signal (*e's autop | Month co use contribute to 12 No 3 Pro 24b. Were autriprior to codeath? No 1 Yes 6 Check ther (Special Variable) t and Number or Rurlate) e(s) and manner as second | he cause of death? bably 4 Junknown posy findings available posy fin |
| ttending Physicien: The law requires that the death certificate death. Geath. ctor: After this certificate has been signed by the attending phy; y the funeral director, page 2 should be detached for use as the | To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | d. 23c. If yes, outded to the program of the progra | come of pregnancy th 2 Fetal de- ant at time of death wn ath but not resultin patient 2 ER. if Injury h, Day Year) 28 of Injury - At home g, etc. (Specify) best of my knowle- lisis of examination | /ath 3 h 5 ming in the unit of | other (specify) nderlying cause g at 3 DOA 28c. Inj W M 1[eet, factory, office | 26. Place ther: 4 Nury at ork? Yes 2 | 24a. 1 O of Death (Check arsing Home 5 Death (C | 1 ☐ Yes Was an autopsy performed (es 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 | Month co use contribute to 12 No 3 Pro 24b. Were autriprior to codeath? No 1 Yes 6 Check ther (Special Variable) t and Number or Rurlate) e(s) and manner as second | he cause of death? bably 4 Junknown posylindings available impletion of cause of 2 No No A Route Number, stated. o the cause(s) |
| or Attending Physicien: The law requires that the death certificate for deceath. Ifter deceath. Iftector: Attentis certificate has been signed by the attending physiciector. Page 2 should be detached for use as the next of the funeral director, page 2 should be detached for use as the | edical Certification: To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | d. 23c. If yes, outd 1 | come of pregnancy th 2 Fetal de ant at time of death wn ath but not resultin ath but not resultin ath but not resultin ath but not resultin 2 ER if Injury h, Day Year) 28 of Injury - At home g, etc. (Specify) best of my knowle sis of examination er stated. | //Outpatier //Outp | other (specify) nderlying cause g at 3 DOA 28c. Inn W M 1[eet, factory, office th occurred at the exestigation, in my | 26. Place ther. 4 Numry at ork? Yes 2 time, date an opinion, dea | 24a. 1 O of Death (Check arsing Home 5 Death (C | 1 ☐ Yes Was an autopsy performed (es 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 | Month co use contribute to to 2 No 3 Pro 24b. Were authorior to death? 1 Yes 6 1 ther (Specification) 1 tand Number or Runtate) e(s) and manner as and place, and due to the second | he cause of death? bably 4 Junknown posylindings available impletion of cause of 2 No No A Route Number, stated. o the cause(s) |

| | | | For State Registrar | State of Ma | | Depa | | of H | | lental Hy | | 06 | 37924 |
|---------------------|---|------------------|---|--|---------------------------------|-----------------------------|--------------------------|------------------------------------|--|---|-------------------------------|---|---|
| x 3 | Physicia | an | 1. Decedent's Name (First, Middle, Las | t) | | | | | | 2. Date of Dea Month Nov 20, | | Year | 3. Time of Death |
| | /Medic | al | Stanley | | Horv | vath | | | | Nov 20, | 4c. County | (D 1) | 9:30 pm ^м |
| - | Examin | er | 4a. Facility Name (If not institution, give 43 Somerville Ave | | | | Cum | | Location of Death and | | Allega | | |
| | Funeral Director | | 5. Social Security Number 6. Se | | e (In yrs. last b | oirthday) Yrs. | If Under | | If Under 24 Hrs. Hours Min. | 8. Date of Birt Month, Da Feb 2, | | _ | place (State or Foreign ntry) |
| | Maryland -1 show | tor | Usual Residence of Decedent 10a, State 10b, County MD Allegar | ıy | 10c. City, To | | cation perlan | d | | | | 1 | 10d. Inside City Limits 1 □X es 2 □ No |
| | 3a or 28a | Funeral Director | 10e. Street and Number 43 Somerville Ave | nue | | | 10f. Zip | | 21502 | - Anna - | 10g. Citizen of | What Cour | ntry? |
| 9036 | I within 72 hours after death with the Maryland ilen. Jen. Jen. Jen. Jen. Jen. Jen. Jen. J | þ | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Armed Forces? 1 Ves 2 1 If Yes, Give Year or Dates: | | 1 | Vas Decede Yes, speci | | spanic Origin? (Sp n, Mexican, Puerto Specify: | ecify Yes or No Rican, etc.) | | ce · Americ ick, White, ^{fy:} whit | etc. |
| 1215-0 | vithin 72 h ne. han *natu e Medical | Completed | 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) | | 5+) | a Deced (Give life. D | | l Occupa k done d e retired, | ation luring most of work) | ing | 16b. Kind of B | | ocal 568 |
| Maryland 21215-0036 | be filed stal Hygi od other | To Be Co | 17. Father's Name (First, Middle, Last) Frank Horwath | | Le | abol c | 71 | - | 18. Mother's Nam | e (First, Middle, Nudry) H | Maiden Sumai | | _0001 000 |
| Mary | 12 sh h and 7 is rr traurr | F | 19a. Informant's Name/Relationship (1 Madeline Horwath | | 19 | 9b. Mailin 43 S | g Address omer | (Street a | Avenue | al Route Numbe | er, City or Town Derland | , State, Zic | у Со.de) MD 21502 |
| Baltimore, | Pages 1 and 3 nent of Health int: If Itam 27 iry or other tr | | 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific | | 20b. Place cemei Rocky | terv, cren | natory or ot | her place | | Date 11/27/20(| 20c. Location 6 Flintsto | | own, State |
| Baltii | permit. Pag Department Important: I eny injury o | | 21. Signature of Fluneral Service Licer | | 20: | 22 | | | Funeral H | | land. MD | 21502 | 1 |
| | Physician /Medical Examiner | | 23a. Part 1. Enter the disease, or coin shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | a Ends | the death. Done. | CF | er the mode | of dying | g, such as cardiac | or respiratory a | rrest, | | Approximate Interval Between Open and Death |
| 760, < | icate be executed physician and s the burial-transit | cal Examiner | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | с. | a consequenc | | | | | | | | |
| .O. Box 68 | The law requires that the death certificat, sie has been signed by the attending phy page 2 should be detached for use as the | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome 1 Live birth 4 Pregnant al 9 Unknown | 2 Fetal dea | | Ectopic pre | | | | | ate of deliv | ery Day Year |
| rds, P | quires that n signed b uld be deta | ρ | Part II. Dther significant conditions of | ontributing to death b | ut not resulting | g in the ur | nderlying ca | ause give | en in Part I. | 23e. Did t | _/ | | he cause of death? |
| I Records, | | Completed | | | | | | | | 24a. Was auto perio 1 🗆 Yes | osy ormed? | prior to co death? | opsy findings available ompletion of cause of |
| Vital | ysician: Th is certificate director, pag | Be | 25. Was case referred edical examiner? | Handal. | | | | 011 | 26. Place of Dea | th (Check only o | one) | | |
| of | ing Phys | tion: To | 1 Yes 2 No 27. Manner eath 1 tural 5 Pending 2 Accident investigation | Hospital: 1 Inpatie 28a. Date of Inju (Month, Da | ıry 28b | Outpatien Time of Injury | | 8c. Injun | 4 Li Nursing II | ome 5 Amesi 28d. Describe | dence 6 Ot how injury occu | | fy) |
| Division | al or Attending s after death. If Director: After id in by the fune | Certification: | 3 Suicide 6 Could not b | e 28e. Place of In | jury - At home, c. (Specify) | farm, str | eet, factory | , office | | 28f. Location (City or To | | ber or Run | al Route Number, |
| | To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by | edical C | | ysician: To the best niner: On the basis o and manner st | f examination | | | | | | | | |
| | To the To the comp | Me | 29b. Signature and title of certification | 11/ | 10- | ^ | 29c | | e number | | 29d. Date sign | | |
| | | | | vago | rum | | | D | 22181 | | Novemb | er S | 21,2006 |
| | 10 | | 30. Name and address of person who | | | | | | | | | | |
| | Sta | ate | Gary Wagoner N | M.D. 33 Registr | ar's Signature | | |) Wa | lsh Drive | Cumber | land ML | 215 | 02 |
| | Regist | rar | NOV 2 9 20 | NG Beauce | J. K. | Son | ALLE | | | | | | |

| 111010 | | | alo / til | ٦٥٦ | | 710 | 49.0 | 194 | 0 | -7 | 0 |
|--------|----|--------|-----------|-------|----|-------|------|-----|---|----|---|
| ment | of | Health | and M | ental | Ну | giene | UU | 0 | J | 1 | _ |
| | | | | | | | | | | | |

| | | | 1 - State Registrar | | Cei | rtificate of l | Death | | Reg. No |). | | |
|----------------------------|---|------------------|---|---|----------------------------------|---|--------------------|-------------------------------|------------|---|-----------|---------------------------------|
| | | | 1. Decedent's Name (First, Middle, Last, |) | | | | 2. Date of D | | | | 3. Time of Death |
| н | Physici /Medio | | JOCELYN V | EE JOHNSON | | | | North | .ber | | ar ၁၁६ | 12:30AM |
| + | Examir | | 4a. Facility Name (If not institution, give | | | 4b. City, Town, or | Location of Deat | | | . County of D | | |
| | | | PRINCE GEORGE'S H | OSPITAL | | CHEV | ERLY | | P | RINCE | GEO | RGE'S |
| | Funeral | | 5. Social Security Number 6. Se | | last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of B | idh | 9 | | ce (State or Foreign |
| | Director | | 578-84-6173 ¹⁰ | ^{™ 2} ₹ 48 | Yrs. | Months Days | Hours Min. | JAN 3 | 0 19 | 58 WA | SHI | NGTON, DC |
| | ק | | Usual Residence of Decedent | | | | | | | | | |
| | nylan how | | 10a. State 10b. County | | ity, Town or Lo | | | | | | 100 | 1. Inside City Limits |
| | a-f-s | cto | MD PRINCE G | EORGE'S | HYAT | TSVILLE | | | | | | Yes 2 No |
| | or 28 | lre | 10e. Street and Number | | | 10f. Zip Code | 0705 | | 10g. Ci | tizen of What | Country | y? |
| | th wi | a | 1705 COLUMBIA AVE | NUE | | 2 | 20785 | | U.5 | 5.A. | | |
| | dee | Funeral Director | 11. Marital Status | 12. Was Decedent Ever in U Armed Forces? | J.S. 13. | Was Decedent of H | ispanic Origin? (S | pecify Yes or N | 0- | 14. Race - A | | |
| ဖွ | or Ite | | 1 ☐ Never Married 2 ☐ Married | 1 ☐ Yes 2 No If Yes, Give | | 1 ☐ Yes 2 🛣 No | | o riioan, etc.) | | Black, W | | |
| ဋ္ဌ | ral', | d by | 3 ☐ Widowed 4 ☐ Divorced | Year or Dates: | | 1 1 482 SV 140 | эрөспу. | | | Specify: | ЪГ | ACK |
| ည် | within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f show ha Medical Examinar must be notified at | Completed | 15. Decedent's Edu (Specify only highest grad | cation le completed) | 16a. Dece | dent's Usual Occupa | ation | rkina | 16b. K | and of Busine | ss/Indu | stry |
| 7 | ithin Ben Me | du | Elementary/Secondary (0-12) | College (1-4or 5+) | life. | kind of work done of DO NOT use retired | 1) | | | | | |
| 7 | filed w Hygier ther th | ပိ | 12TH | | ENVIR | MENTAL SI | ERVICES | | PI | RIVATE | | |
| 힏 | be fill tal H d off | Be | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nar | | | Sumame) | | |
| y a | should Ind Men | 5 L | DEECONSTINE JOHNS | SON SR. | | | MARY G. | SPRIGGS | 5 | | | |
| Maryland 21215-0036 | and and is mu | | 19a. Informant's Name/Relationship (T) | | | ng Address (Street a | | | | | | |
| 2 | and salth n 27 | | SHANIKA JOHNSON/I | DAUGHTER | 1705 | COLUMBIA | AVENUE 1 | HYATTSV | ILLE, | MARYLA | AND | 20785 |
| ore. | ges 1 and 2 should be filed within 72 hours after deeth with the Marylan at of Health and Mental Hygiene. If Item 27 is marked other than "naturat", or Itema 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at | | 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ F | | Place of Dispo cemetery, crer | sition (Name of matory or other place | e) | Date | 20c. L | ocation - City | or Tow | n, State |
| Ĕ | Peges nent of a ant: If Its ury or o | | 4 □Donation 5 □Other (Specify) | | SURRECT | TION CEME | TERY 11/ | 15/2006 | CL | INTON, | MARY | LAND |
| Baltimore, | permit. Pege Department of Important: If any injury or once. | | 21. Signature of Function Service Licens | 00 | 22 | 2. Name and Addres | ss of Facility | J. B. J. | ENKTI | VS FUN | ERAI | . HOME |
| 8 | 8 G E E 8 | | | > | - | 7474 LAND | | | | | | 20785 |
| | | | 23a. Part1. Enter the disease, or composhock, or heart failure. List only o | ications that caused the dea | | | | | | 111111111111111111111111111111111111111 | A | Approximate Interval Between |
| | Physician | | Immediate Cause (Final | | we | Parson | oxie C | 100 | | | Ċ | Inset and Death |
| | /Medical | | disease or condition resulting in death) | a. Due to (or as a consec | | IMACAS | 02/100 | MICIN | 0 24 | | - | |
| | Examiner | | | | , | | | | | | | |
| | | Jer | if any, leading to immediate | b. — Due to (or as a consec | quence of): | · | | | | | + | |
| | uted | 直 | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | |
| o, | exec n an rial-tr | Examiner | resulting in death) Last | Due to (or as a consec | quence of): | | | | | | | |
| 68760, | certificate be executed iding physicien and ise as the burial-transit | /Medical | | d | | | | | | | İ | |
| 68 | tifica g ph as th | ed | | | | | | | | | | |
| Вох | n cer andin use | | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregn | | De | | | | 23d. Date of | delivery | |
| Ω. | deatl | Cla | in the past 12 months? 1 □ Yes 2 □ No | 1 Live birth 2 Feta 4 Pregnant at time of a | | ∃Ectopic pregnancy] Other (s <i>pecify)</i> | | | | Month | D | ay Year |
| P.O. | t the by th | Physicia | 9 🗆 Unknown | 9□Unknown | | | | | | | | |
| | The law requires thet the death ate has been signed by the etter page 2 should be deteched for u | by P | Part II. Other significant conditions co | ntributing to death but not res | sulting in the u | nderlying cause give | en in Part I. | 23e. Did | tobacco | use contribut | e to the | cause of death? |
| Ë | quire on sig uld b | pe | Gartointer | and Hem. | sulvege | | | 1 🗆 | Yes 2 | 100 3 □ | Probab | oly 4 □Unknown |
| ပ္ပ | s bee | Completed | Obstruction | Jandus | • | | | 24a. Wa | s an | 24b. Were | autons | y findings available |
| æ | he la e ha | E | 0 4 | F:0. | | | | auto perf | ormed? | prior | to comp | elion of cause of |
| Division of Vital Records, | in: T ificat or. p | | 25. Was case referred to medical | factive | | | 00 Pi (D- | 1□ Yes | 2 NO | 1 1 | /es 2 | No |
| Ē | Attending Physician: r death. ector: After this certifics by the funeral director, t | o Be | examiner? | lospital: 1 Inpatient 2 |] ER/Outpatier | t 3 DOA Othe | 26. Place of Dea | | | - 55 | -5.0 | |
| ð | Phy or this sral d | . To | 27. Manner of Death | 28a. Date of Injury | 28b. Time of | IL 3 DOA | 4 🗆 Nursing P | lome 5 ☐ Res 28d. Describe | | | ipecify) | |
| 5 | th. Frunce | ţ. | 1 Alatural 5 Pending 2 Accident investigation | (Month, Day Year) | Injury | f 28c. Injury Worl | k? Yes 2 ⊡No | | | , | | |
| is! | Atter dea | flea | 3 Suicide 6 Could not be | 28e. Place of Injury - At h | nome, farm, str | reet, factory, office | | 28f. Location | (Street ar | nd Number or | Rural F | Route Number |
| á | effer Dire din b | Certification: | 4 Homicide determined | building, etc. (Speci | fy) | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | City or To | own, State | 9) | | |
| | Hospital 24 hours Funeral tely filled | | 29a. Certifier Certifying Phy | sicien: To the best of my kn | owledge, deat | h occurred at the tin | ne, date and place | , and due to the | cause(s | and manner | as state | ed. |
| | To the Hospital or Attending Physician: The law requires that the death within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the etter completely filled in by the funeral director, page 2 should be deteched for up | edical | (Check only 2 Medical Exami | ner: On the basis of examination and manner stated. | ation and/or in | vestigation, in my of | pinion, death occu | rred at the time | , date an | d place, and | due to th | ne cause(s) |
| | To the within 2 To the complex | Me | 29b. Signature and title of certifier | 25 0 | | 29c. License | e number | | 29d. Da | te signed (Me | onth, Da | y, Year) |
| | | | > K Marka | 1 Fun | ~ | Dog | 52845 | - | | | | 2006 |
| 0 | 10 | | 30. Name and address of person who co | ompleted cause of death /lte | m 23al (Tyne | | 24,00 | | | • | | tree, - |
| K | (8) | | K. MICHAEL FIGAR | | | | HEVERLY, | MARYLA | ND 2 | 0785 | | |
| | Sta | ite | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | | | | | | | | |
| | Registr | | NOV 1 6 2006 | | A. A. | | | | | | | |

| | | | 1 - State of Man | - | artment of Hertificate of L | | | giene | 37926 |
|------------|--|----------------|--|------------------------------------|---|------------------------|--------------------------------------|--------------------------------------|---------------------------------------|
| | * 3 | - | Decedent's Name (First, Middle, Last) | | | | 2. Date of Dea Month | | 3. Time of Death |
| | Physicia /Medic | | James Edward Jones | - | | | Novemb | | 3:20 A M |
| | Examin | | 4a. Fecility Name (If not institution, give street and number) | | 4b. City, Town, or | Location of Death | 1 | 4c. County of Dea | |
| | | € | 5000 Lydianna Lane #216 | (la la eè la imbala) | Suitlar If Under 1 Year | nd If Under 24 Hrs. | 8. Date of Birt | Prince Ge | |
| | Funeral Director | | 1₩ 2∏F | (In yrs. last birthday) Yrs. | Months Days | Hours Min. | NOv.12, | | thplace (State or Foreign ountry) |
| | ס | | Usual Residence of Decedent | | | | 11011129 | 1737 7.431 | |
| | ırylan show | _ | , | 10c. City, Town or Lo Suitland | | | | | 10d. Inside City Limits 12 Yes 2 □ No |
| | 8a-1 | Director | Maryland Prince Georges | | 10f. Zip Code | | | 10g. Citizen of What C | |
| | with t | Dir | 10e. Street and Number | | 20746 | | | United Sta | |
| | deeth ms 23 | Funeral | 5000 Lydianna Lane #216 11. Marital Status 12. Was Decedent Ev. | er in U.S. 13. | Was Decedent of Hi | spanic Origin? (S | pecify Yes or No- | | erican Indian, |
| 036 | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show entry or other traumatic event, Ire Madical Examinar must be notified at once. | by Fur | 11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Event Armed Forces? 1 1 □ Yes 2 □ No Year or Dates: | 1/27759 | 1 Tes, specify Cubai | Specity: | o Alcan, etc.) | Specify: B | |
| 21215-0036 | 72 ho | Completed by | 15. Decedent's Education (Specify only highest grade completed) | (Give | dent's Usual Occupa kind of work done of | luring most of wor | rking | 16b. Kind of Business | /Industry |
| 121 | within | mpi | Elementary/Secondary (0-12) College (1-4or 5+) | | DO NOT use retired, | | | Private | |
| d 2 | Hygie Hygie other | ပိ | 12 17. Father's Name (First, Middle, Last) | MOI | rtgage Spe | | ne (First, Middle, | Maiden Surname) | |
| lan | lid be fental rked c | To Be | Walter M. Jones | | | Maebel: | le Scott | | |
| Maryland | and N is ma | | 19a. Informant's Name/Relationship (Type, Print) | | • | | | er, City or Town, State, | |
| 2 | and solution and s | | Collette Jones - Wife | 20b. Place of Dispo | Lydianna | Lane #2. | Date | 20c. Location - City of | 20746 |
| nore | ages intoffice. If ite | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | cemetery, cre | matory or other place and Veterar | | 15/2006 | | |
| Baltimore, | permit. P Departme importan eny injur. | | 21. Signafure of Funeral Service Libensee | | | | | 1 Homes, Md | |
| | . 79. | | 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. | | | | | | Approximate Interval Between |
| 5 | Physician | | Immediate Cause (Final disease or condition | stice He | ort Fai | lura | | | Onset and Death |
| 1/2 | /Medical Examiner | | resulting in death) Due to (or as a continuous) | consequence of): | | | | | |
| | Examine | _ | Se ventially list conditions. b. Diake | Les consequence on. | | | | | |
| | ted nsit | Examiner | cause. Enter Underlying Cause (Disease or injury | sonosquones on. | | | | | |
| ó | icate be executed physicien and s the burial-transit | | that initiated events c. Pue to (or as a control of the control of | consequence of): | | | | | |
| 8760, | ate be hysicie | licai | d | | | | | | |
| 9 | the death certificate y the attending physiched for use as the i | Med | IF FEMALE: 23c. If yes, outcome of | foregrancy | | - | | and Date of de | li con |
| Вох | attend for us | Physician/M | in the past 12 months? | Fetal death 3 | ☐Ectopic pregnancy ☐ Other (specify) | | | 23d. Date of de Month | Day Year |
| o. | at the de by the a | ysic | 1 Yes 2 No 9 Unknown 9 Unknown | | 324 | | | | |
| α. | res that signed b | by Pi | Part II. Other significant conditions contributing to death but | not resulting in the t | anderlying cause give | en in Part I. | 23e. Did to | obacco use contribute | |
| ğ | equire en sig ould b | | | | | | 10` | Yes 2 □ No 3 □ F | Probably 4 Tunknown |
| Records, | The law requires that sete has been signed b page 2 should be deta | Completed | | | | | 24a. Was autor perfo 1 Tyes | | |
| Vital | Physician: T rthis certificat ral director, pa | Be | 25. Was case referred to medical examiner? | | Oth | | ath Check only | one | |
| of | Physic this c | -T | 1 ☐ Yes 2 ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ | | | 4 Nursing r | γ | dence 6 Other (Sp. | ecify) |
| on | ding F th. After funer | tion | 1 SNatural 5 Pending (Month, Day' 2 ☐ Accident investigation | Year) Injury | Worl | k? Yes 2 □ No | | and any account | |
| Division | l or Attending after death. Director: After I in by the fune | Certification: | a Constitution of Constitution | y - At home, farm, st (Specify) | treet, factory, office | | 28f. Location (. City or Tot | Street and Number or F wn, State) | Rural Route Number, |
| _ | To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by | Medical C | 29a. Certifier (Check only one) 1 Certifying Physician: To the bast of e and manner state | examination and/or in | | | | | |
| | To the within 2 To the complet | Me | 29b. Signature and title of certifier | | 29c. License | e number | | 29d. Date signed (Mor | nth, Day, Year) |
| 1 | 2 | | CITCH IV | | Do | 10534 | 19 | 11/14/06 | |
| (| SILA | | 30. Me e and a Tress of person who completed wise of dea | ath (Item 23a) (Type | Print) OC 2 | . 7.7 | | | |
| σ. | 1 0 17 | | 31. Date filed (Month, Day, Year) 32. Registrar | osning for | 110 2 | 0)6/ | | | |
| | St: Regist | ate rar | | Soule? | | | | | |

| | | | 1 - For State Registrar | State | of Maryla | • | artment rtificate | | | | - | | 00 | 6 3 | 37927 | |
|---------------------------------------|--|---|---|---|---|--|--|--|----------------------------|-----------------|--|---------------------------|---|----------------------------------|--|--|
| - | Physici | an | Decedent's Name (First, Middle | _ | | | | | | | 2. Date of De Month Novem | ath Da | y 1 2 | Year | 3. Time of Death | |
| | /Medic | | Claudia 4a. Facility Name (If not institution | B. | umber) | Jorda | | Town, or | Location of | of Death | Novem | | . County of | | 4:00A M | |
| | Examili | iei | 5901 Walleye | | , | | , , | ldor | | | | | Char. | | | |
| ** | Funeral Director | | 5. Social Security Number 228-58-4025 Usual Residence of Decedent | 6. Sex 1 ☐ M 2 🛣 F | | 1 Yrs. | If Under Months | 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bir (Month, Da Nov. 16 | th 17. Year) 5 , 19 | 944 V | 9. Birthplac Country Vashi | e (State or Foreign Ington, DO | |
| | ith the Maryland or 28a-f show | Director | 10a. State 10b. County Maryland Char 10e. Street and Number | | | ity, Town or Lo | 10f. Zip | Code | | | | 10g. Cit | 10d. Inside City Limits 1 ☐ Yes 2√ No Citizen of What Country? | | | |
| 036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, if a Medical Exacultar mast ke redified at once. | d by Funeral Director | 5901 Walleye 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced | 12. Was De Armed F ied 1 ☐ Yes If Yes, G | 12. Was Decedent Ever in U.S. Armed Forces? | | | 20603 Was Decedent of Hispanic Origin? (Spetif Yes, specify Cuban, Mexican, Puerto F | | | | | | | · American Indian, , White, etc. Black | |
| Maryland 21215-0036 | within 72 h iene. 'than "natu | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 1 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Administrative Ass | | | | | | | rking | | | of Business/Industry ral Government | | | |
| /land | ould be fited Mental Hyg arked other atic event, | To Be C | 17. Father's Name (First, Middle, John Carroll | Ballou | | | | | Lue | Му | e (First, Middle, rtle | Edm | onds | 5 | | |
| Mar | nd 2 sh alth and 27 ls m r traum | | 19a. Informant's Name/Relations: Donna A. Lawr | | ughter | | | | | | al Route Numbe Waldor | | | | | |
| Baltimore, | Pages 1 ar lent of Hea nt: If Item 7 | | 20a. Method of Disposition \$\infty \begin{array}{ccccc} \text{8 urial} & 2 \text{Cremation} \\ 4 \text{Donation} & 5 \text{Other} \(S_i \) | | 20b. Re | Place of Dispo cemetery, crei SUTTEC | osition (Nam matory or oth Ction | e of her place Cel | mete | ov. | 18,200 | 6ººº. Lo Cli | nton | ity or Town | , State | |
| Balti | permit Departn Imports any inju | | 21. Signatur of Funeral Service | 5. K. | des | 6 | 160 | Oxo | n Hi | 11 I | | xon | Home Hil | , P.2 1, MI | A. D 20745 | |
| · · · · · · · · · · · · · · · · · · · | Physician /Medical Examiner | | 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Liver dysfunction Due to (or as a consequence of) Sequentially list conditions Due to Tolon Cancer | | | | | | | | | | | | terval Between | |
| 8760, | cate be executed physician and the burial-transit | If any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | | | | |
| P.O. Box 68 | Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 1 Live | utcome of pregn birth 2 Pet mant at time of nown | al death 3 | Ectopic pre Other (spe | | | | | | 23d. Date of Month | | y Year | |
| | w requires that is been signed by should be deta | by | Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of de 1 Yes No 3 Probably 4 Ui 24a. Was an autopsy performed? 1 Yes 22 No 1 Pos 20 No | | | | | |
| Il Records, | The law recate has been page 2 sho | Completed | | | | | | | | | | | | etion of cause of | | |
| ₹ ₹ | sician certifi irector |) Be | 25. Was case referred to medical examiner? | Hospital: | 1 | 2500 | | Othe | · · | | Check only o | | | | | |
| Division of Vital | ing Viter | ation: To | 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig | 28a. Date (Mo. | Inpatient 2[of Injury oth, Day Year) | ER/Outpatier 28b. Time of Injury | | c. Injury Work | 4 📋 NUI | | me 5½ Resid 28d. Describe h | | | | | |
| Divis | al or Attend s after death I Director: A id in by the f | Certification: | 3 Devisite 6 Decuid not be | | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | o the Hospital or thin 24 hours after the Funeral Dir mpletely filled in | edicai C | 29a. Certifier 1 Certifyin (Check only one) | g Physician: To the | e best of my kn basis of examin nner stated. | owledge, death ation and/or in | n occurred a vestigation, | it the tim | e, date and inion, deat | d place, a | and due to the ed at the time, | cause(s) date and | and mann place, and | er as state d due to the | d. e cause(s) | |
| | To the within 2 To the comple | Me | 29b. Signature and title of certifier | | | | ١. ١ | _ | number | | | | e signed (| Month, Day | i, Year) | |
| 2 | (6) | . 00 | · COLLYC | Who | | | | D | ∞ | 20 | 0050 |) | 13 | 14/0 | 70 | |
| _ | (6) | | 30. Name and address of person | wno completed cau | ise of death (Ite | m 23a) (Туре, | all 1 | 221 | Mer | can | tile I | n., | Larg | 10, M | ID 10774 | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 1 5 2006 | berew | Registrar's Sign | Spell | j | , | | | | | | | | |

| | | | For State Registrar | State of Maryla | nd / Depa | artmer | nt of H | lealth ar Death | nd Menta | al Hygier | | 37928 | | |
|---------------------|--|---------------------|--|---|--------------------------------------|------------------------------------|--------------------------|-------------------------------|---|----------------------------------|---|-------------------------------------|--|--|
| | Physici | an | Decedent's Name (First, Middle, Last) LAW RENCE | Rahapt | | iEb | | | Mo | te of Death | Day Year | 3. Time of Death | | |
| | /Medic Examir | | 4a. Facility Name (If not institution, give | 0 / 1 | ~ / | | | Location of | | NEMbe | 5R 9, 2001 4c. County of Death | | | |
| 4 | Funeral | | 5. Social Security Number 6. Sep | TORO AVE | s. last birthday) | If Unde | T 1 Year Days | If Under 24 | A Hrs O Day | te of Birth | 9. Birth | place (State or Foreign | | |
| | Director | | 213-30-3018 Usual Residence of Decedent | \$M 2□F | 75 Yrs. | WOTHERS | Days | nouis | May | 18, 19 | 31 Mary | | | |
| | l ehow | ō | 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore City | | | | | | | | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No | | | |
| | or 28a-f | rect | MaryLand 10e. Street and Number | Вал | timore | | p Code | | | 10g. (| Citizen of What Country? | | | |
| | ath wil | ralD | 4614 Frankford Aver | | | 206 | | | USA | Α | | | | |
| 980 | 2 should be filed within 72 hours after death with the Maryland and Memberla Hygiens. Is marked other than "natural", or Iteme 23s or 28s-f show aumstic event, the Modical Examinar must be notified at | by Funeral Director | 11. Marital Status 1 X Never Married 2 Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Ever in Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1950 | | If Yes, specify Cuban, Mexican, Pu | | | | es or No- etc.) | 14. Race - Amer Black, White Specify: Whi | , etc. | | |
| 2-0 | 72 ho "natura | eted | 15. Decedent's Educ (Specify only highest grade | 15. Decedent's Education (Specify only highest grade completed) | | | | | of working | 16b. | Kind of Business/Ir | | | |
| 212 | d within giene. er then the Me | Completed by | Elementary/Secondary (0·12) | College (1-4or 5+) | Printe | po noti er | ise retired |) | | Pri | inting | | | |
| and | Id be filed vental Hygie ked other i ic event, II | To Be | 17. Father's Name (First, Middle, Last) Josef Lieb | | | | | s Name (First, sia Scl | | Maiden Sumame) der | | | | |
| Maryland 21215-0036 | s 1 and 2 should if Heelth and Mer Item 27 is marke other traumatic | | 19a. Informant's Name/Relationship (Type, Print) Theresa M. Manke/POA/Executor 19b. Mailing Address (Street and Number or Rural Route Num 740 Falconer Road Joppa, MI | | | | | | | MD 210 | ber, City or Town, State, Zip Code) 21085 | | | |
| Baltimore, | | | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory 11/10/06 Beltsvill | | | | | | | | | | | |
| Baltir | permit. Pages Department of Important: If It eny injury or once. | | 21. Signature of Funeral Service License | | | | | | | 6 Bel ervice | ltsville, P.O. Bo | MD x 784 | | |
| | 40200 | | 23a. Part1. Enter the disease, or complishock, or heart fallure. List only or | cations that caused the de | 1251 Be | everl | y L. | Heckr | otte, I | P.A. CI | larksvill | e, MD 21029 | | |
| | Physician /Medical | | shock, or heart failure. List only on fimmediate Cause (Final disease or condition resulting in death) | Due to (or as a conse | Hic | Me | 1 | nom | _ | | | Interval Between Onset and Death | | |
| | Examiner | er | Sequentially list conditions, if any, leading to immediate | | | | | | | | | | | |
| | xecuted and Il-transit | Examin | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conse | equence of): | | | | | | | | | |
| 8760 | cate be executed physician and the burial-transit | dicalE | L _a | | | | | | | | | | | |
| .O. Box 6 | that the death certific led by the attending p detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | □Ectopic pregnancy □ Other (specify) | | | | | 23d. Date of delivery Month Day Year | | | | | |
| J | es that igned b be deta | þ | Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I. | | | | | | | | uid tobacco use contribute to the cause of death? | | | |
| Vital Records, | age age | Completed | | | | | | | | a. Was an autopsy performed? | opsy findings available impletion of cause of | | | |
| <u> </u> | Physician: 1 this certifical | Be | 25. Was case referred to medical examiner? | ospital: | - | | Othe | | f Death (Check | k only one | | | | |
| ō | ding Phys h. After this funeral di | n; To | 27. Manner of Death | 28a. Date of Injury | ☐ ER/Outpatien 28b. Time of | | 28c. Injury Work | 4 140121 | - | Residence scribe how inj | 6 Other (Special | (y) | | |
| DIVISION | Attending or death. ector: After by the fune | catlo | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | (Month, Day Year) | fnjury | М | | ? ′es 2 □ No | | | | | | |
| 2 | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi | Certification: | 4 Homicide determined | 28e. Place of Injury - At building, etc. (Spec | city) | | | | City | or Town, Sta | | | | |
| | Hoep 24 hou Funer etely fill | edical | 29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin | icien: To the best of my kr er: On the basis of examin and manner stated. | nowledge, death nation and/or inv | occurred restigation | at the tim , in my op | e, date and p inion, death | place, and due occurred at the | to the cause(e time, date ar | s) and manner as s nd place, and due to | tated. the cause(s) | | |
| | To the within 2 To the complet | Me | 29b. Signature and title of certifier | 1 0 | | 290 | c. License | number | | 29d. D | ate signed (Month, | Day, Year) | | |
| لم | 1). | | 30. Name and address of person who con | Ale M | - (2a) (T -) | D | 28 | .44 | 7 | Nou | IEMBER | 9,2006 | | |
| 01 | 100 | | Panayiolis A. Balta | ityis, M.D. | 8113 Ha | | d Rd | . Suit | e 100 I | Parkvi1 | lle, MD 2 | 1234 | | |
| 4 | Sta Registr | | 31. Date filed (Month, Day, Year) | 32. Fagistra r's Sign | nature | | | | | | | | | |

| | | | For State Registrar | | State of | Maryland | | | | lealth a Death | nd Mer | | giene Reg. No. | 2006 | ; 3 | 7920 |
|-----------------|---|---------------------|--|---|---|--------------------------------------|--|--|---|-------------------------------|-------------------------------|--|--|-------------------------------|--|---------------------------|
| | Physici /Medic | | 1. Decedent's Nam | | 2. Date of Do Month Novembe | | | | Month | r 8 | Year 2006 | 10 | me of Death | | | |
| 1 | Examir | | 4257 Bri | ght Bay | | | | I | Ellic | Location of ott Ci | ity | 4c. County of Death Howard | | | | |
| 2 | Funeral Director | | 5. Social Security N 218 54 0 Usual Residence of | 547 | . Sex 7. 1 □ M 2/2 F | Age (In yrs. Ia | Yrs. | Months | er 1 Year Days | If Under 2 | Min. 12 | Date of Birti (Month, Day 2/31/1 | 948 | 9. Bir Ma | thplace (S puntry) rylan | tate or Foreign |
| | tryland show d at | _ | 10a. State | 10b. County | | | Town or Lo | | | | | | | | | de City Limits |
| | he Ma 28a-f s otified | ecto | MD 10e. Street and Nu | Howard | | Ellicot | | | | tt City 10f. Zlp Code | | | | en of What Co | | Yes AND No |
| | with 1 | I Di | 4257 Bri | | Wav | | | 101. 2 | 2104 | 2 | | | USA | | | |
| 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral Director | 1 Never Married 2 Married 1 If Ye | | | es XXNo | | | _ Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 | | | | | | merican Indian, hite, etc. White | |
| | | To Be Completed | (Spec | Education grade completed) College (1-4 | or 5+) | (Give life. I | dent's Usual Occupation kind of work done during most of working DO NOT use retired) | | | | | | d of Business | Industry | | |
| 2 | | Con | | | | | Secre | etary | <i>!</i> | 40.11.11.1 | 1. N (F) | | Medical | | | |
| Maryland | | To Be | | Francis | Sauers, 3 | r. | | | | Rosal | | sephi | ne No | owakowa | | |
| | | | 19a. Informant's N Michelle | ame/Relationship Kensick | (Type. Print) xi/d aughte | | 273 I | Lodes | stone | ct. | Westm | unste | er, City or Er, MI | Town, State, 211! | | |
| Baltimore, | | | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory 11/10/2006 Catonsville, M | | | | | | | | | | | te | | |
| Balti | | | 21. Signature of Fr | uneral Service Lic | Delde | M01442 | 22 | 2. Name a | and Addre | ss of Facility | Tarry | H. Wi | tzke | 's Fam: t_City | ily F | H Inc. 21043 |
| No. of the last | Physician /Medical Examiner | | 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): | | | | | | | | | | - | Appro: | ximate al Between and Death | |
| 8760, | certificate be executed ding physician and se as the burial-transit | dical Examiner | Sequentially list or if any, leading to ir cause. Enter Undic Cause (Disease or that initiated event resulting in death) | S | с | C | | | | | | | | | | |
| P.O. Box 6 | death certif e attending id for use as | Physician/Med | IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknowr | months? | | h 2 ☐ Fetal nt at time of de | death 3 | Ectopic Other (| pregnancy specify) | / | | | 23 | 3d. Date of de Month | livery Day | Year |
| | requires that the de een signed by the a rould be detached f | b | Part II. Other signi | lficant condition | s contributing to dea | th but not resu | Iting in the u | nderlying | cause give | en in Part I. | | 23e. Did to | | e contribute t | | e of death? 4 ∐Unknown |
| I Records, | The law ate has by page 2 sh | Completed | 24a. Was an autopsy findings prior to completion of code ath? 1 ☐ Yes 2 🗓 No 1 ☐ Yes 2 💆 No | | | | | | | | | of cause of | | | | |
| /ita | sician: Th certificate rector, pag | Be | 25. Was case refe examiner? | rred to medical | Hoonital: | | | | Oth | | of Death (C | | | | | |
| n or Vital | ulng Physician: 1. After this certific funeral director, | on: To | 1 ☐ Yes 2 ☐ 27. Manner of Dea 1 ☑ Natural | th 5 □ Pending | 28a. Date of | natient 2 □ E Injury Day Year) | R/Outpatier 28b. Time o Injury | | 28c. Injur Wor | y at k? | 28d | 5 Resid | | Other (Spe | ecify) | |
| Division | or Attendate death Director: in by the | Certification: | 1 Matural 5 Pending 2 Accident 3 Suicide 4 Homicide 4 Homicide 28e. Place of injury - At homogeneous | | | | | M 1 ☐ Yes 2 ☐ No n, street, factory, office 28f. Location | | | | | (Street and Number or Rural Route Number, own, State) | | | |
| | e Hospital 124 hours e Funeral letely filled | Medical C | 29a. Certifier (Check only one) | 1 Certifying 2 Medical Ex | Physician: To the b caminer: On the bas and manne | is of examinat | vledge, deatl ion and/or in | h occurre vestigation | ed at the tir | ne, date and opinion, deat | d place, and th occurred a | due to the at the time, | cause(s) a date and p | and manner a place, and du | s stated. | use(s) |
| | o the l | Me | 29b. Signature and | title of certifier | | 7 | | 2 | 9c. Licens | e number | | | 29d. Date | signed (Mon | th, Day, Ye | ear) |

Edward J. Lee MD 31. Date filed (Month, Day, Year) NOV 1 3 2006

11065 Little Patuxent Pkwy.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

29d. Date signed (Month, Day, Year) November 9, 2006

Columbia, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year November 11, 2006 Physician Love Robert 3:00 a M Gruver /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Copper Ridge Carroll Sykesville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Win. | July 29, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 M 2 ☐ F 177-05-5503 90 1916 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 □Yes 2 X No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 3148 Gracefield Road, #CL218 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ∏Yes 2√∑No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify:White ltimore, Maryland 21215-0036 1 ☐ Yes 2 No ò 3 Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) than College (1-4or 5+) Electronics permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien
Important: If Item 27 is marked other the Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hattie Gruver Robert H. Love ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3148 Gracefield Road, #CL218, Silver Spring, MD 20904 Bonnie Balzer/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 14 1 N Burial 2 Cremation 3 Removal from State Nov. Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2006 Rockville, Maryland f Funeral Service Licensee Francis Address County Funeral Home Inc. 21. Signatur alier 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Years _aDementia /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transit Due to (or as a consequence of) Box 68760 physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f P.0. 9☐Unknown 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 XNo director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 📆 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 TYes 3 X No 2 ☐ ER/Outpatient 3 ☐ DOA this (Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined

Division or Vital Records,

Registrar DHMH 17 Rev 1/2001

State

29a. Certifier

(Check only one)

29b. Signature and title of cortifier

Wilbur Kuo,

31. Date filed (Month, Day, Year)

NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

32

egistrar's Signature

M.D.

14

Medical

1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

295 Stone Avenue, #307, Westminster, MD 21157

D58137

29d. Date signed (Month, Day, Year)

November 13, 2006

State of Maryland / Department of Health and Mental Hygiene For

| F | Phy | sic | ian |
|---|-----|------|------|
| | /N | ledi | ical |
| | Exa | ami | ner |
| | | | |
| | | | |

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

cate has been signed by the attending physician and page 2 should be detached for use as the burial trans

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical Completed by Be 2 Certification:

| | 1 - State Registrar | | Certificate of Death | | | | | | | Reg. No. 2005 3/93 | | | | |
|--|---|--------------------------------|---|--|-------------------------------|------------------------|--------------------------------|-------------------------------|---------------------------------|--------------------|-------------------|----------------------------|-----------------------------------|---------------------|
| 786 | 1. Decedent's Name (First, Mic | dle, Last) | 2. Date of Month | | | | | ate of Death 3. Time of Death | | | | | | |
| ın al | Louis Kennet | h Lantz | | | | | | | Novem | | | | 6 10 |):05 p ^M |
| er | 4a. Facility Name (If not institut | ion, give street and nur | mber) | | | | r Location o | | | 40 | c. County | of Deat | th | |
| | 11477 Columbia | | | - 41'45 2- 3 | | | Spring If Under | , | 8. Date of Bir | | Mont | | | -4 |
| | 5. Social Security Number 213–42–5904 | 6. Sex 1 ☑ M 2 ☐ F | 7. Age (In yrs. la | a <i>st birtnday)</i> Yrs. | Months | Days | Hours | Min. | Month, Da July 2 | ıv. Year | 941 | l Co | untry) | ate or Foreign |
| | Usual Residence of Decedent | | 10a Ciba | . Town or Lo | ontion | | | | | | | | 40d Incid | do City Limito |
| ō | Maryland Monte | 1 | ity, Town or Location 10d. Inside City Lim 1反Yes 2□ | | | | | | | | | • | | |
| rect | 10e. Street and Number | ,omery | 211 | ver sp | 10f. Zip Code 10g. Citizen of | | | | | | | | untry? | |
| a Di | 11477 Columbia | Pike, Ap | t. D10 | | 209 | | | | | U.S | J.S.A. | | | |
| ner | 11. Marital Status | 12. Was Dece Armed Fo | edent Ever in U.S | S. 13. \ | Was Dece | dent of H | lispanic Ori an, Mexicar | gin? (Spe | ecify Yes or No Rican, etc.) |)- | | ce - Ame | rican India e. etc. | n, |
| Be Completed by Funeral Director | 1 MNever Married 2 M 3 Widowed 4 Divorc | arried 1 ☐ Yes If Yes. Giv | 2 ∑ No ∕e | - | 1 ☐ Yes | | Specify: | | , | 0 % | | | White | |
| eted | 15. Deced (Specify only hig | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | | | | | | Kind of B | dusiness/Industry | | | |
| dmc | Elementary/Secondary (0-12 |) College (| I-4or 5+) | Maile | | | | | | Pri | ivat | <u>.</u> | | |
| ŏ | 17. Father's Name (First, Midd | le, Last) | | | | | | | (First, Middle | , Maide | n Surnar | ne) | | |
| 70 B | Louis Elliot I | | | | Leona | a Vir | ga Edd | s | | | | | | |
| | 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip | | | | | | | | | | Zip Code) | | | |
| | Warren Lantz - Brother 11477 Columbia Pike, Silver Spring, MD 200 | | | | | | | | | | | | | |
| | 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 11/13/2006 Alexandria, Virginia | | | | | | | | | | | | | |
| | 21. Signature of Europeal Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, | | | | | | | | | | e, P. | Α. | | |
| | Malair The 101373 4739 Baltimore Avenue, Hyattsville, MD 20781 | | | | | | | | | | | | | |
| | shock, or heart failure. I | caused the death each line. | n. Do not ent | . Do not enter the mode of dying, such as cardiac or respiratory arrest, | | | | | | | | Approx Interva Onset | rimate Il Between and Death | |
| | Immediate Cause (Final disease or condition resulting in death) | | ectal C | | | | | | | | | | | ears |
| | Toodising in doubly | Due to | Due to (or as a consequence of): | | | | | | | | | | | |
| ē | Sequentially list conditions, if any, leading to immediate | b. — Due to | b | | | | | | | | | | | |
| m: | cause. Enter Underlying Cause (Disease or injury that initiated events | S | | | | | | | | | | | | |
| Exa | resulting in death) Last | Due to | (or as a consequ | uence of): | | | | | | | | | | |
| lical | | d | | | | | | | | | | | | |
| Jegoral Mark State Control of State Cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | | | | |
| | | | | | | | | | | | | ate of del onth | livery Day | Year |
| ıysi | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□Unkn | | | | | | | , | | | | | |
| 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Ves 2 No 9 Unknown 2 Ves 2 No 9 Unknown 2 Ves 2 No 9 Unknown 2 Ves 2 No 9 Unknown 2 Ves 2 No 9 Unknown 2 Ves 2 No 9 Unknown 2 Ves 2 No No 9 Unknown 2 Ves 2 No Ves 2 No Ves 2 No Ves 2 No Ves 2 No Ves 2 No Ves 2 No Ves 2 No Ves 2 No Ves 2 No Ves 2 No Ves 2 No Ves 2 No Ves 2 Ves 2 Ves 2 No Ves 2 | | | | | | | | | use con | tribute to | the cause | e of death? | | |
| ed b | | | | | | 1 🗆 | Yes 2 | 2 X No | 3 □ Pr | robably | 4 □Unknown | | | |
| plet | | | ., | | | auto | a. Was an autopsy findings ava | | | ings available | | | | |
| Com | | | | | | | | | perf 1∐ Yes | ormed? 2 X N | lo | death? 1 ∐ Yes | | |
| Be | 25. Was case referred to med examiner? | 1 | | | | l ou | | | (Check only | | | | | |
| 2 | 1 Yes 2 No | | | ER/Outpatier | | | 4 L N | | me 5 K Res | | | | ecify) | |
| tion: | 27. Manner of Death 1 X Natural 5 □ Per 2 □ Accident inve | ding 28a. Date (Mornstage) | of injury oth, Day Year) | 28b. Time o Injury | M | 28c. Inju Woi 1∐ | ryat rk? ∣Yes 2 🔲 | | 28d. Describe | now inji | ury occu | rrea | | |

State

Cheryl Aylesworth, MD 31. Date filed (Month, Day, Year) NOV 1 5 2006

29b. Signature and title of certifie

6 Could not be determined

2 Accident

3 Suicide

29a. Certifier

4 Homicide

2730 University Blvd. W., Suite 400, Wheaton, MD 20902 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

054378

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

| | | State of Maryland / De | epartment of Health and Mental | | | | | |
|--|----------------|--|--|---|------------------------------|--|--|--|
| | | 1- State Registrar Amend #10e per phys/fh 11-22 | | Reg. No. 2006 3 | 1932 | | | |
| Physic | cian | Decedent's Name (First, Middle, Last) | 2. Date Mon | th Day Year | e of Death | | | |
| /Med | lical | Henry Lach 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | mber 11 2006 8:3 | 5 A " | | | |
| Exam | iner | Lorien Life Center | Mt. Airy | Carrol1 | | | | |
| Funera | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birth. | Months Days Hours Min. (Mor | of Birth 9. Birthplace (Standth, Day, Year) Country) | | | | |
| Directo | r | 019-09-6067 92 11 | s. July | y 4, 1914 Massachus | setts | | | |
| yland how | | 10a. State 10b. County 10c. City, Town of | or Location | | e City Limits | | | |
| ie Mar Ba-fsh otified | Director | | . Airy | | Yes 2□No | | | |
| with the | Dire | 10e. Street and Number 713 Midway Avenue, #209 | 10f. Zip Code 21771 | 10g. Citizen of What Country? | | | | |
| ING 21213-UU36 be filed within 72 hours after death with the Maryland tital Hygiene. Indicate than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Funeral | | 13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e | S or No- btc.) United State 14. Race - American Indian Black, White, etc. | | | | |
| after or ite | | 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give | 1 ☐ Yes 2 ☒ No Specify: | Specify: White | | | | |
| 5-UU36 72 hours af natural", or | ed by | 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. □ | Decedent's Usual Occupation | 16b. Kind of Business/Industry | - | | | |
| rin 72 | Completed | (Specify only highest grade completed) | Give kind of work done during most of working life. DO NOT use retired) | | | | | |
| d 21212 filed within Hygiene. other than "ent, the Mec | Com | 12 Pro | duction Superintendent | Optical | | | | |
| land Id be file ental H ked oth c even | Be | 17. Father's Name (First, Middle, Last) | | Name (First, Middle, Maiden Surname) | | | | |
| e, Maryla 1 and 2 should Health and Men em 27 is marke ther traumatic | 은 | Stanley Lach 19a. Informant's Name/Relationship (Type. Print) 19b. 1 | | la Wisniewska or Rural Route Number, City or Town, State, Zip Code) | | | | |
| Math a 27 is r tra | | | 00 Hunting Lodge Court | Vienna, Virginia 2 | | | | |
| Itimore, it. Pages 1 a intment of Hee intent: If Item | F | 1 Negrial 21 ICremation 31 Removal from State 1 | Disposition (Name of Date November | 20c. Location - City or Town, State | • | | | |
| tim trent tant: I | | 4 □ Donation 5 □ Other (Specify) Pine G | rove Cemetery 15, 2006 | 6 Mt. Airy, Maryl | and | | | |
| Balt permit. Depart Import any inj | Olice | 21. Signature of Funeral Service Licensee | 8 E. ridgeville Blvd. | Mt. Airy, Maryland | A. 21771 | | | |
| 2,200 | | 23a. Part1. Enter the dilease, or complications that caused the death. Do no shock, or heart fail inc. List only one caus. On each line. | t enter the mode of dying, such as cardiac or respir | atory arrest, Approxi Interval Onsetra | mate Between and Death | | | |
| Physicia /Medica | | Immediate Cause (Final disease or condition resulting in death) | Meumonia | WK | -5 | | | |
| Examine | _ | Die to (or as a consequency of | nla | 41 | ک^ | | | |
| 7 5 | ner | Sequentially list conditions, listy had by h | n 11 1/2 | 1/4/10 | ks | | | |
| 60, be executed ician and burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last C. | 7 CONGESTIVE HOPEN | TTAILORE W | KJ | | | |
| 60, be ex sician burial | 超 | chronic re | Pagestive Home | NCY 41 | ^ < | | | |
| 687 tificate g phys | | 0 | | | | | | |
| Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ | 3 □Ectopic pregnancy | 23d. Date of delivery Month Day | Year | | | |
| O. E ne dea the at hed fo | /sici | 1 □ Yes 2 □ No 9 □ Unknown | 5 ☐ Other (specify) | | | | | |
| 1S, P.O. Ires that the de signed by the a | | | | e. Did tobacco use contribute to the cause | of death? | | | |
| Records, he law requires to has been signe | Completed by | COTONARY Artery disease | Domentia Shile | 1 ☐ Yes 2 No 3 ☐ Probably 4 | Unknown | | | |
| Reco le law re has bee | plet | Benign Prostatic Hypertrop | phy, anemia 24 | a. Was an autopsy finding autopsy autopsy 24b. Were autopsy finding prior to completion | ngs available of cause of | | | |
| The The page | Com | | 1 | performed? death?] Yes 2 No 1 □ Yes 2 No | | | | |
| vision or Vital Reattending Physician: The death. ector: After this certificate his yet the funeral director, page | Be | 25. Was case referred to medical examiner? | 26. Place of Death (Chec | | | | | |
| on or ding Phys After this funeral did | To | 27 Manager of Booth 29h Ti | | ☐ Residence 6 ☐ Other (Specify) escribe how injury occurred | | | | |
| sion (ending F ath. or: After he funer | atio | 1 Natural 5 Pending (Month, Day Year) 1 Natural 2 Accident investigation | M 1 Yes 2 No | | | | | |
| Division or a rending Physafter death. Director: After this in by the funeral di | Certification: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify) | | cation (Street and Number or Rural Route y or Town, State) | Number, | | | |
| Spital ours a neral C | | | death occurred at the time, date and place, and du- | e to the cause(s) and manner as stated. | | | | |
| Divisit To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and and manner stated. | /or investigation, in my opinion, death occurred at the | ne time, date and place, and due to the cau | | | | |
| To th Voithill To th | × | | 29c. License number | 29d. Date signed (Month, Day, Ye | | | | |
| | | 30. Name and address of person who completed cause of feath (Item 23a) (I | [Vine Print] | 11 12 20 | 0,60 | | | |
| IA | | ALEN KEILLY, WD 801 | Toll House Ave | D-1, FREDERIC | K, MD | | | |
| | State | 31. Date filed (Month, 120 Ver) 4 2006 32. Referrar's Signature | | | , | | | |
| Regi | strar | | | | | | | |

State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month M **Physician** Edward Robert Lawson Jr. November 12, 2006 1:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 23664 Keen Road Chance Somerset If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Yeer) **Funeral** Days Hours 1X M 2□ F 73 Yrs. 023-26-8443 12/30/1932 Director Massachusetts Usual Residence of Decedent death with the Maryland 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Maryland Somerset Chance 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23664 Keen Road 21821 USA Funeral 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 XYes 2 □ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Army 1 ☐ Yes 2 X No Specify: Specify: white ģ 3 Widowed 4 Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) College/ 12 Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ith and Mental F 27 is marked of traumatic ever Elizabeth Fredrickson Edward Robert Lawson Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health at: if item 27 is you other tra Health a Fredrick S. Lawson/son 55 Salem St., Methuen, Mass 01844 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Spring Grove 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Andover, MA Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Holloway Funeral Home Professional Association Kutt 501 Snow Hill Rd., Salisbury, MD 21804 23a. Pert1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate . Interval Between Onset and Death Immediate Cause (Final genous **Physician** wfe myeldisease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the buriat-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 2 No 1 ☐ Yes Completed peeu ; 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes _ 2 No 2 this 28a. Date of Injury (Month, Day Year) To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and granner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 030690 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll 51, 51:500, MD 21801 M.D. 145 E. Dones E-MARTIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Show It speck

| | | | For State Registrar | State of | Marylan | | artmen rtificato | | | nd M | | giene Reg. N | | 37934 |
|--------------|--|-------------------|---|---|---------------------|------------------------------|---|--------------------------------------|----------------------------------|-----------|---------------------------------------|-------------------------------|-----------------------------|--|
| 5 | Physici | an | Decedent's Name (First, Middle, La. Joan | Meac Meac | 7 | | Lin | tner | | | 2. Date of Dea Month | Day | 2006 Year | 3. Time of Death 9:24 p M |
| | /Medio | -20 | 4a. Facility Name (If not institution, give | | | | | | Location of | f Death | | | County of Dea | |
| | _Xuiiiii | | Casey House | | | |] | Rock | ville | | | Mo | ntgome | ry |
| 87 | Funeral Director | | | ex 7. | Age (In yrs. 91 | last birthday) Yrs. | If Under Months | 1 Year Days | If Under 2 Hours | Min. | 8. Date of Birt (Month, Da 9/11 | h y, Yea <i>r)</i> /191 | 9. Bir | thplace (State or Foreign ountry) ndia |
| | and sw | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | y, Town or Lo | cation | | | | | | | 10d. Inside City Limits |
| | a-fshk ifieda | ctor | WV Morgai | ı | I | Berkele | ey Spa | ring | S | | | | | 1 □Yes ¾ ∑ No |
| · . | or 28 be not | Director | 10e. Street and Number | | | | 10f. Zip | | 444 | | | - | en of What C | ountry? |
| | eam v ns 23a must | Funeral | 2904 Spriggs Roa | 12. Was Decede | ent Ever in U. | S. 13. V | Was Decec | | 411 | in? (Spe | cify Yes or No | | U.S.A. | erican Indian. |
| 5-0036 | s I and z should be lied within /z hours arter death with rire maryland f Health and Mental Hygiene. If Health and Mental Hygiene. If the the street of the rithan "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | þ | 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced | Armed Force 1 ☐ Yes 3 If Yes, Give Year or Date | es? ∰ No | | lfYes,spec 1⊡Yes] | _ | | Puerto | cify Yes or No- Rican, etc.) | | Black, Whi | te, etc. |
| 15-0 | n /z no n "natur fedical | Completed | 15. Decedent's Ed (Specify only highest gre | de completed) | | 16a. Deced (Give life. | dent's Usua kind of wor DO NOT us | al Occupa rk done d se retired | ation furing most | of workin | ng | 16b. Kir | nd of Business | /Industry |
| 2121 | med within Hygiene. Ither than " | Som. | Elementary/Secondary (0-12) | College (1-4 | or 5+) | 2 | [eache | er | | | | Е | ducatio | on |
| | tal Hy doth | Be | 17. Father's Name (First, Middle, Last, | | | Ma | | | | | (First, Middle, | Maiden S | • | , |
| Maryland | z snould bert and Mental is marked of aumatic eve | 은 | Walter 19a. Informant's Name/Relationship (| Type Print) | | Mea 19b Mailir | | (Street a | | nevie | I Route Numbe | er City or | | ohnson Zin Code) |
| | Tand 2 s Health an tem 27 is other trau | | John C. Lintner | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | • | • | | | , Washi | . , | | , , , |
| ore, | 0 0 | | 20a, Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ | Removal from St | 0 | Place of Dispo | sition (Nan | ne of ther plac | e) | D | ate | 20c. Loc | cation - City or | Town, State |
| Baltimore, | tmen tant: njury | | 4 ☐ Donation 5 ☐ Other (Specif | v) | Hig | ghland | | | | | | | | prings, WV |
| Bal | Depar Impor any ir | lo y | 21. Signature of Funeral Service Licer | De ral | _M0052 | $\frac{2}{1}$ | elsie | a Addres SY-Jo | ss of Facility Dhnsor S+ E | rui | neral H | ome, | Inc. | 25411_1855 |
| The state of | | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that cau | used the deat | h. Do not ent | er the mod | e of dyin | g, such as o | cardiac o | r respiratory ar | rest, | 5, WV | Approximate Interval Between |
| | hysician | | Immediate Cause (Final disease or condition resulting in death) | a. Glic | blast | ona | | | | | | | | Onset and Death 3 months |
| | /Medical Examiner | | resulting in dealiny | Due to (or | as a conseq | uence of): | | | | | | | | |
| | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury | b. Due to (or | as a conseq | uence of): | | | | | | | | |
| V | be executed sician and burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c | as a consequ | uence of): | | | | | | | | |
| 8760, | law requires mar the death cermicate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit | | | d | ao a conceq | donoc ciy. | | | | | | | | |
| 89 | nuncate ng phys as the | Medic | The results | su | | - | | | | | | | | |
| Вох | eath cerund attending p | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | | th 2 Feta | l death 3 |]Ectopic pr | | | | | 2 | 3d. Date of de | livery Day Year |
| P.O. I | at the de by the a stached f | ıysic | 1 □ Yes XX No 9 □ Unknown | 4∐Pregnar 9∏Unknow | nt at time of d | eath 5 | Other (sp | ecify) | | | | | | , |
| S, P | res mar igned b be deta | by Pt | Part II. Other significant conditions | ontributing to deat | th but not res | ulting in the u | nderlying c | ause give | en in Part I. | | 23e. Did to | obacco us | se contribute t | o the cause of death? |
| ord | w require been sij should t | | | | | | | | | | 1 🗆 \ | res XT | ₹No 3□P | robably 4 □Unknown |
| Records, | ine iaw ate has b oage 2 st | Completed | - | | | | | | | | 24a. Was autop | | 24b. Were a prior to death? | utopsy findings available completion of cause of |
| | | | 25. Was case referred to medical | | | | | | 26 Plans | of Dooth | | 2 €XNo | 1 ☐ Yes | 2 XX 10 |
| > | ysicia is cert directi | To Be | examiner? 1 \(\sum \text{Yes} 2\sum \text{Yo} | Hospital: 1 ☐ Inp | oatient 2 🗆 | ER/Outpatier | nt 3 DC | Othe | | | | | ₩ther (Spe | ecify) Hospice |
| n or | aing Fn h. After thi funeral | | 27. Manner of Death 1 XX atural 5 ☐ Pending | 28a. Date of (Month, | Injury Day Year) | 28b. Time o Injury | f 2 | 8c. Injun Worl | | | 28d. Describe h | | | in in the second |
| Division | Attending Proystotan: r death. ector: After this certific by the funeral director, | catio | 2 Accident investigation 3 Suicide 6 Could not be | | f injury - At ho | omo form etr | M Page factors | | Yes 2□N | | 19f Logotlan / | Ctmet a se | d Alumbas as 7 | ural Route Number, |
| 5 | al or A s after or al Direct od in by | Certification: | 4 ☐ Homicide determined | | , etc. (Specif | | eet, ractory | , onice | | | City or Tox | | | urai noule Number, |
| | I o the Hospital of Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Medical (| 29a. Certifier (Check only one) Certifying Property 2 Medical Example 1 | | is of examina | | | | | | | | | |
| | vithir To th | Me | 29b. Signature and title of certifier | ~ | 1 | | | | number | | | | signed (Mon | |
| | ^ | | Eynthia W. | sul | lear | no | _ | 0058 | 032 | | | voven | iber 22 | , 2006 |
| | 17 | | 30. Name and address of person who | • | , | , , , , , | | 34'7 | 1 5 | , . | , | | | _ |
| | Sta | 2 | Cynthia M. Willi 31. Date filed (Month, Day, Year) | 34 neu | gistrar's Signa | T MILLIC | ster | MIL | T KOS | a, R | ockvill | е, М | ນ 2085. | |

| | | | 1 - State Registrar | State of M | Marylar | | | | ealth a | | | giene Reg. Ne. | | 06 | 270 | 135 |
|---------------------------------|---|----------------|---|--|--|---|----------------------------|---------------------------|--------------------------|--------------------------|---------------------------------|-------------------------|------------------|----------------------------|--|------------|
| | | | Decedent's Name (First, Middle, La. | st) | | - 001 | incai | COIL | | | 2. Date of Dea | EN | . U | 00 | 3. Time of | f Death |
| | Physici | | JEAN LAUIAN | 10 | | | | | | | Month / O | Day 2-8 | ζ | Year 2006 | 11:15 | . 0 |
| | /Medio Examir | | 4a. Facility Name (If not institution, give | | r) | | 4b. City. | Town, or | Location of | of Death | 10 | | | ty of Death | 11.13 | |
| | LAGIIII | iei | UNIVERSITY OF M | | | 1 CENTED | | | MORE | | | | | imore | City | |
| | Funeral | | 5. Social Security Number 6. S | ex 7. A | | last birthday) | If Unde | r 1 Year | If Under | 24 Hrs. | 8. Date of Birt | h | 16 | 9. Births | lace (State o | or Foreign |
| | Director | | 119-20-8715 | □M 2 X) F | 79 | Yrs. | Months | Days | Hours | Min. | (Month, Da) August 28 | | 27 | New Y | | |
| | p , | | Usual Residence of Decedent | | 1400 | | | | | | | | | | | |
| | ehov | - | 10a. State 10b. County | | 10c. Cit | ty, Town or Lo | cation | | | | | | | 1 | 0d. Inside C | * |
| | Ba-f | Director | Maryland St. Mary's | | | Leonar | | | | | | | | | | 2 🔯 No |
| | with t | ā | 10e. Street and Number | | . # 1 1 | 1 / | 10f. Zip | Code | | | | 10g. Citiz | ten of | What Cour | ntry? | |
| | ss 23 | Funeral | 22680 Cedar Lane | Court, A | | | Mas Dass | 206 | | -i=2 (C== | aif. Van an Na | | 14 De | USA | an Indian | |
| | ter d | Š | 1 □ Never Married 2 □ Married | Armed Forces | ? | - 1 | | | | | cify Yes or No- Rican, etc.) | . ' | | ce - Americ ack, White, | | |
| 39 | urs al | þ | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates | | | I □ Yes | 24 No | Specify: | | | | Speci | か: Whi | te | |
| Ģ | within 72 hours after death with the Maryland one. Then "naturel", or items 23a or 28a-f ehow the Medical Exercit er maral be notified at | Completed | 15. Decedent's Ed | lucation | | 16a. Deced | lent's Usu | al Occupa | ition | | | 16b. Kir | nd of E | Business/In | dustry | |
| 2 | Pn"n | pje | (Specify only highest gra | de completed) College (1-4o | r 5+) | life. L | Kind of wo DO NOT u | erk done d se retired, | lu <i>ring</i> mosi) | t of workir | ng [| | | | · | |
| 7 | gien gien er th | Con | 12 | | | Hospi | tal A | Admin | istra | ator | | Hos | spi | tal | | |
| g | be filed within 72 hours after death with the Marylan to they gions. I have seen that the manual terms 23a or 28a-1 show a other than "naturel," or liems 23a or 28a-1 show event, it a Medical Exactlinat must be notified at | Be (| 17. Father's Name (First, Middle, Last) | | | | | | 18. Mothe | | (First, Middle, | | | me) | | |
| yla | should be nd Mentel marked c | ပ္ | Harry Carty | | | | | | | Mary | Brodmo | erke: | 1 | | | |
| ar | and lem | 0.3 | 19a. Informant's Name/Relationship (| Type, Print) | | | | | | | Route Numbe | - | | | Code) | |
| 2 | end eelth m 27 her ti | | Michael Laviano/ | Son | | - | | | Zepl | | Cove, N | | _ | | | |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should by Department of Health and Mante Important: If item 27 is marked eny injury or other traumetic av <u>once.</u> | | 20a. Method of Disposition 1 ☐ Burial 2 ☼ Cremation 3 ☐ | Removal from Stat | e 206. P | Place of Disportence | sition (Nar natory or c | ne of other place | 9) | o Novemb | ate per 1 | 20c. Loc | ation | - City or To | wn, State | |
| Ë | . Pa tmen tant: | | 4 Donation 5 Other (Specify | 1) | | ropolita | | | 7 | 200 | | A1ex | and | ria, V | A | |
| 3ai | Depar Depar Impor Impor ony in | | 21. Signature of Funeral Service Licen | see | 7 | | | | s of Facility | | 7 77 | D 4 | 4 | 1590 Fe | enwick S | Street |
| _ | auseu | | Justil K. | Bardin | / | | | | | | eral Home | | L | eonard | | |
| Н | | | 23a. Part1. Enter the disease, or compshock, or heart failure. List only | one cause on each | ed the deat line. | h. Do not ente | er the mod | le of dying | , such as | cardiac o | respiratory ari | rest, | | | Approximate Interval Bet Onset and I | ween |
| • | Physician | | Immediate Cause (Final disease or condition resulting in death) | a. LEFT | POSTER | IUR CE | REBRA | L AR | TERY | 15 CH | EMIC ST | ROKE | - | | 6 DA | 45 |
| | /Medical Examiner | | 1 | Due to (or a | s a conseq | uence of): | | | | | | | | | | |
| | | - | Sequentially list conditions, | b. Due to (or a | s a consec | uence of): | | | | | | | | | | |
| V | nsit | nin. | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | | | | | | | | | | |
| | al-tra | Examiner | that initiated events resulting in death) Last | C. Due to (or a | s a conseq | uence of): | | | | | | | | | | |
| 8760, | icate be executed physicien and s the burial-transit | dicai | (| d. | | | | | | | | | | | | |
| 89 | tificat ng ph) as th | edi | <u> </u> | | | | | | | | | | | | | |
| Вох | that the death certif ed by the attending detached for use a | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcom 1 ☐ Live birth | | | Ectopic pr | | | | | 2: | 3d. Da | ate of delive | iry | |
| <u> </u> | deal deatt | sicie | in the past 12 months? | 4☐Pregnant | | | Other (sp | | | | | | Mo | onth | Day ት | Year |
| o. | at the | Å. | 9 Unknown | | | | | | | | | | | | | |
| Ś | w requires tha been signed should be det | Ď | Part II. Other significant conditions of | | | | derlying c | ause give | n in Part I. | | 23e. Did to | bacco us | e con | tribute to th | e cause of d | eath? |
| ord ord | equir sen s | Completed | ATRIAL FIBRI HATIO | nypen | LIENS | 1014 | | - | | | 1 U Y | es 2□ |] No | 3 Prob | ably 4 □L | Jnknown |
| Ö | law les b | pie | | | | | | | | | 24a. Was a autop: | | 24b. | Were autop | osy findings a | available |
| <u> </u> | The page | Sol | | | | | | | | | perfor | | | death? | 2□ No | |
| = | cian: ertific ector, | Be | 25. Was case referred to medical examiner? | | | | | | | | Check only or | 70) | | | | |
| | hysi this c | P | 1 ☐ Yes 2 No | | | ER/Outpatient | | A Othe | r: 4 🗆 Nur | rsing Hom | e 5 Resid | ence 6 | □Ot# | her (Specify | ') | |
| ב | ing F | Ö | 27. Manner of Death 1 ☑Natural 5 ☐ Pending | 28a. Date of In (Month, D | ury ay Year) | 28b. Time of Injury | | 8c. Injury Work | | | 8d. Describe h | ow injury | occur | rred | | |
| Sic | oteath. | cat | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | | | | М | | es 2 N | | | | | | | |
| Division of Vital Records, P.O. | l or A after Direc I in by | Certification: | 4 ☐ Homicide determined | 28e. Place of II | njury - At no atc. <i>(Specif</i>) | ome, farm, stre | et, factory | , office | | 2 | 8f. Location (S City or Town | treet and n, State) | Numi | ber or Rura | l Route Num. | ber. |
| _ | pital ours eral filled | | 29a. Certifier 1 Certifying Ph | veicine: To the bee | t of my keep | utadaa daath | | -445 - 41 | | | | | | | | |
| | To the Hospital or Attending Physician: The law requires that the death certific within 24 hours afterd crath. To the Functal Director attent of the completely filled in by the funeral director, page 2 should be detached for use as | Medical | (Check only 2 Madical Examone) | ysician: To the bes iinar: On the basis and manner s | of examina | tion and/or inv | estigation | in my op | inion, deat | n piace, a th occurre | d at the time, d | ause(s) a late and p | ind ma place, | anner as st and due to | ated. the cause(s |) |
| | of this | Me | 29b. Signature and title of certifier | | | | 290 | . License | number | | 2 | 29d. Date | signe | ed (Month, I | Day, Year) | |
| | ->-0 | | 1 /200 1/ | 1 | | | 10 | 197 | 96 | | | | | 1/20 | | |
| | | - | 30. Name and address of person who | completed cause of | death (Item | 23a) (Type F | | | | | | | 10 | 1 20 | 0 | |
| | 5 | | DANICA NOVACI | C 22 | 5. GK | LEENE | ST | BALT | I MOR. | E. W | 10 212 | 01 | | | | |
| | Sta | te | DANICA NOVA CI 31. Date filed (Month, Day, Year) NOV 2 9 20 | 32 Regis | trar's Signa | ture A | 60 | | | -1-1 | | - 1 | | | | |
| | Registr | ar | NOV 2 9 20 | 06 100 | as D | F. GOS | | | | | | | | | | |

| | | | | For State Registrar | State of | Marylar | | artmen <i>tificat</i> | | | | lental Hy | /gier Reg. I | $2 \mathrm{n}$ | 06 | 37936 |
|----------|------------|--|----------------|--|---|--|-----------------------------------|--------------------------|--------------------|--------------------------|-------------------------|-----------------------------------|------------------------|-----------------------------|--------------------------|--|
| | | | | 1. Decedent's Name (First, Middle, La | st) | | | | | | | 2. Date of D Month | | Day | Year | 3. Time of Death |
| _ | | Physicia /Medic | | Helen Mae Mar | tin | | | | | | | Nov. 5 | | 006 | | 2:20 A M |
| T | 7 | Examin | | 4a. Facility Name (If not institution, give | | oer) | | 4b. City, | Town, or | Location | of Death | | | 4c. County | | |
| - | | | | Stella Maris Hos | | | | | oniu | | 24 Ueo | | | Balt | | |
| | Н | Funeral Director | | 5. Social Security Number 219–36–4043 | Sex 1 □ M 2 K F 7. | | last birthday) Yrs. | Months | 1 Year Days | If Under Hours | Min. | 8. Date of B | ay, Yea | ar) | | lace (State of Foreign etry) |
| | | | | Usual Residence of Decedent | | 67 | / | | | L | | April_ | . و⊥ | 1939 | Augu | sta Virgin |
| | | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28s-f show important: If tem 27 is marked other than "satural Examinar must be mailfied a sny injury or other traumatic swent, the Medical Examinar must be mailfied a once. | Director | 10a. State 10b. County Maryland Washingt 10e. Street and Number | ton | | ty, Town or Lo | | Code | | | | 10a | Citizen of V | | 0d. Inside City Limits 1 Yes 2 No |
| | | with with | ă | 11617 Robinwood I | rivo | | | | 742 | | | | - | S.A. | viiai ooui | idy i |
| | | eath | era | 11. Marital Status | 12. Was Deced | ent Ever in U | .S. 13. V | Was Dece | dent of H | ispanic O | rigin? (Sp | ecity Yes or N | | | e - Americ | an Indian. |
| а.ш. | 21215-0036 | urs after d al', or Iten Exeminer | by Funerai | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forc 1 ☐ Yes 2 If Yes, Give Year or Date | es? No | | fYes, spe 1 ☐ Yes | cify Cuba | in, Mexica Specify | ın, Puerto | Rican, etc.) | | | k, White, | etc. |
| 0 | Š | 72 ho | ted | 15. Decedent's E (Specify only highest gr | ducation | | 16a. Deced | dent's Usu kind of wo | al Occupa | ation | st of work | ina | 16b. | Kind of Bu | | |
| 2:20 | 2 | thin 7 | Completed | Elementary/Secondary (0-12) | College (1-4 | for 5+) | life. | DO NOT u | se retired | () | SI OF WORK | urg | | | | |
| | 7 | ygien ygien ver th | S | 12 | | | | | | | | | | Reta | | |
| 2006 | Maryland | be fill htal H od ott | Be | 17. Father's Name (First, Middle, Last | ") | | | | | | | e (First, Middle | | | ie) | |
| 50 | <u> </u> | I Men | ဥ | Ray Smoot | | | T | | | | | | Rouz | · · · · · · | | |
| 5 | Маг | 12 sh hand 7 Is m traum | | 19a. Informant's Name/Relationship (| | | | • | | | | al Route Numi | | | | |
| | | 1 and Health em 27 ther tr | | Tammy R. Spivey A | Daugnte | | 9477 Place of Dispo | | | . DII | | 1236 Ba | | Linore Location - | | |
| BE | ٥ | Pages not of int: If It iry or o | | 1 Burial 2 ☐ Cremation 3 ☐ | | ate | cemetery, cren | natory or o | other plac | | | | | | | |
| NOVEMBER | | it. Partme | | 4 □Donation 5 □ Other (Special Service Lies | | Res | st Have | n Cer | | | | 9/2006 st Hav | _ | | | laryland |
| S (| Ba | permit. Depertr Imports sny injt | | 9 611 | | | | | | | | | | | | and 21742 |
| | | ΪŒ | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final | one cause on each | used the dear | | | - | | - | | | | | Approximate Interval Between Onset and Death |
| | E | Physician physician floating the physician and physician and step phys | dicai Examiner | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | bDue to (or | r as a consec | quence of): | | | | | | | | | |
| 1 | | The law requires that the death certific lie has been signed by the atlending p bage 2 should be detached for use as i | Physician/Mec | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | | th 2 ∏ Feta ntattime of o | al déath 3□ | Ectopic p | | | | | | 23d. Dat Mor | e of delive | ery Day Year |
| _ | ds, P. | uires that signed b d be deta | Ď | Part II. Other significant conditions | contributing to dea | th but not res | sulting in the u | nderlying o | ause give | en in Part | I. | | | | | ne cause of death? |
| Z | Records, | 2 38 | Completed | | | | | | | | | 24a. Wa auto per | s an opsy formed | | prior to con death? | psy findings available inpletion of cause of |
| HELEN | | ificate or, pa | Ö | 25. Was case referred to medical | T | | | | | 26 Plac | o of Dogst | 1 ☐ Yes h (Check only | | No 1 | Yes | 2∐ No |
| | > | Physician: r this certificanal director, | ToB | examiner? 1 ☐ Yes 2 🕱 No | Hospital: | patient 2 |] ER/Outpatier | t 3 □ D0 | OA Othe | | | | | 6 XIOth | er (Specifi | HOSPICE |
| Ì | on of | nding Pthys th. r: After this e funeral di | | 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation | 28a. Date of (Month, | | 28b. Time of Injury | | 28c. Injun Worl | | | 28d. Describe | | | | , HOULTON |
| | Division | To the Hospital or Attending Physician: The within 24 hours effor death. To the Funeral Director: Affer this certificate h completely filled in by the funeral director, page | Certification; | 3 Suicide 6 Could not to determined | 28e. Place o | f Injury - At h g, etc. <i>(Speci</i> | ome, farm, str | eet, factor | y, office | | | 28f. Location City or To | | | eror Rura | l Route Number, |
| | | n 24 hour | Medical | 29a. Certifier (Check only one) 1 | hysician: To the b miner: On the bas and manne | is of examina | owledge, death ation and/or in | occurred vestigation | at the tin | ne, date a pinion, de | nd place, ath occurr | and due to the red at the time | cause , date a | e(s) and ma and place, a | nner as st and due to | ated. the cause(s) |
| | | To t To t | Σ | 29b. Signature and title of certifier | | | | 290 | - | number | | | 29d. I | Date signed | , , | |
| |) | | | | 15- | | | | 1)6 | 137 | 21 | | | 11/ | 6/06 | 2 |
| _ | 21 | 1-2 | | 30. Name and address of person who | completed cause | of death (Iter | m 23a) (Type, | Print) | | | | | | | | |
| (| 91 | 1-2 | | DR. TARIQ MAHMOO | | | Y VALLE | EY RD | . T | IMON] | LUM,M | D 2109 | 3 | | | |
| | | Sta Registr | | 31. Date filed (Month, Day, Year) | 2006 | gistrar's Sign | 15. B. | cette | , | | | | | | | |

| Type of Time in Black | K IIIGEIIDIE IIIK. | Elisaic Ali | sobies vie | ream |
|-----------------------|--------------------|---------------|--------------|------|
| State of Maryland / F | Department of H | ealth and Mer | ntal Hygiene | 200 |

37938 State of Maryland / Department of Health and Mental Hyglene / 📙 🖯 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month **Physician** 7, LOWELL JACK MYERS NOV. 2006 4:35 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

74 Yrs. Months Days Hours Min. JAN. 26, 19 POTOMAC VALLEY NURSING HOME MONTGOMERY 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ₹M 2 □ F Director 1930 CALIFORNIA 345-22-1065 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10h Counts 10d. Inside City Limits ir then "naturel", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1√2 Yes 2 No Director COOK CHICAGO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1060 WEST NORTH SHORE AVE. 60626 U.S.A. deeth \ by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. 3 X Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ LAWYER SEARS CORPORATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ JOSEPH MYERS ANNIE SCHAEFER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MYERS/DAUGHTER 7315 WILDWOOD DR., TAKOMA PARK, MD. 20912 LYNDA R. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 11-8-2006 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. namerial M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 - 4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line: Approximate interval Between Onset and Death Immediate Cause (Final **Physician** SUBARACHNOID HEMORRAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2X No 1 ☐ Yes 2 ☐ No After this certification, I or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Manual Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitei within 24 hours To the Funeral 1 CCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 40051280. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DADGAR, M.D. 9715 MEDICAL CENTER DR. #201, ROCKVILLE, MD. 20850 ANUSHIRAVAN 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

NOV

08

2006

parte

State of Maryland / Department of Health and Mental Hygiene 37939 For State Registrar <u>AMEND#20loperFH11/8/06, BMW, McCo</u> Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year WILLIAM DAVID McCAMPBELL, SR. NOVEMBER 4, 6:15 PM 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CASEY HOUSE MONTGOMERY ROCKVILLE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 □ F Yrs. Director 579-26-4237 80 NOVEMBER 9, 1925 DISTRICT OF COLUMBI Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 2 Stown.

2 Stown.

2 Stown.

3 In Medical Hygiene.

3 In marked other then "natural", or items 23s or zero.

4 In marked other then "natural", or items 23s or zero. Director 1 ☐ Yes 2 X No MARYLAND MONTGOMERY SILVER SPRING 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? 601 COPLEY LANE 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 1 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC 12 ELEVATOR COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 VICTOR ALEC McCAMPBELL. SR. VERLA FOX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 MARTHA J. McCAMPBELL - SPOUSE 601 COPLEY LANE, SILVER SPRING, MARYLAND 20904 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ō = cemetery, crematory or other place) 1 ₺ Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If any Injury or once. 11-8-2006 4 ☐ Donation 5 ☐ Other (Specify) UNION CEMETERY BURTONSVILLE, MARYLAND 21. Signature of Funeraf Service Licensee 22. Name and Address of Facility Myelin T. Klobert HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Finaf Physician disease or condition resulting in death) SEPTICEMIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signe should be 2 E.S.R.D. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No C.H.F. 24a. Was an page 2 s autopsy performed? certificate 1 ☐ Yes 2 🗓 No Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death Check only one Hospital: 1 __fnpatient 2 __ ER/Outpatient 3 __ DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) HOSPICE 1 Yes 2 No After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred s effer dec. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide filled in 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ynthia m Williams, DO 1+0058032 NOVEMBER 5, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CYNTHIA M. WILLIAMS, D.O., MONTGOMERY HOSPICE, 6001 MUNCASTER MILL ROAD, ROCKVILLE, MARYLAND 20852 31. Date filed (Month, Day, Year) 32. Signature State NOV 08 Registrar

| | | | 1 - State of Maryland State of Maryland Registrar | / Depa <i>Cer</i> | irtment of H tificate of L | ealth and M <i>Death</i> | | 2006 | 37940 |
|----------|---|------------------|---|----------------------|---|---|--|-------------------------------|---|
| - | Physicia | an | 1. Decedent's Name (First, Middle, Last) Walton E. McBride, Jr. | | | | 2. Date of Death Month | Day Year | 3. Time of Death |
| | /Medic | al | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or | | November | 11, 2006 4c. County of Dea | 10:30 A ^M |
| | Examin | er | 4202 Elizabeth Street | | Rockvil | | | Montgome | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. las | V | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Y | ear) 9. Bir | thplace (State or Foreign ountry) |
| × | Director | | 439-42-8255 B0 | O Yrs. | | | Jan 15, | | isiana |
| | ryland how at | , | | Town or Loc | cation | | | | 10d. Inside City Limits |
| | Ba-f s | ecto | 0 0 | kvi11 | T | | | | 1 ☐ Yes 2 🕅 No |
| | with the a or 2 the ne | Funeral Director | 10e. Street and Number 4202 Elizabeth Street | | 10f. Zip Code | 0853 | | Citizen of What Conited Sta | * |
| | death ms 23 | nera | 11 Marital Status 12. Was Decedent Ever in U.S. | 13. V | | spanic Origin? (Spe n, Mexican, Puerto | | 14. Race - Ame | erican Indian, |
| 0000 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | oy Fui | Armed Forces? 1 □ Never Married 2 🖾 Married 1 □ Never Married 2 🖾 Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: ₩₩II | | Yes 2 No | | Hican, etc.) | Specify: W | |
| 5 | 72 hou natura dical E | Completed by | 111122 | (Give k | ent's Usual Occupa | urina most of workii | 16 | b. Kind of Business | Industry |
| 7 | within sne. | mple | Elementary/Secondary (0-12) College (1-4or 5+) | life. D | OO NOT use retired) | , | | Civil Eng | ineer |
| 7 | filed y | Be Co | 17. Father's Name (First, Middle, Last) | 2116111 | | 18. Mother's Name | | | Lifect |
| land | uld be Mental Irked (| To B | Walton E. McBride Sr. | | | Mary Ra | gan | | |
| | 2 sho l and l is ma rauma | · | | | - | | | City or Town, State, | . / |
| ນ໌ ນ | 1 and Health em 27 | | Lucile F. McBride (Wife) 20a. Method of Disposition 20b. Plac | | ELIZADETI sition (Name of patory or other place | | | c. Location - City or | |
| Daltimor | Pages ment of ant: If it | | | | tan Crem | | | Lexandria | |
| סשור | permit. Departr importa any inj | | 21. Signature of Fundal Service Licensee | | Name and Addres 0 East De | | Vol Funer Dr. Gaith | | Md. 20877 |
| ı | | | 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. | Do not ente | r the mode of dying | g, such as cardiac o | r respiratory arrest | , | Approximate Interval Between |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) a. Convestive H | | Failure | | | | Onset and Death Hours |
| | Examiner | | Due to (or as a consequer Ischemic Card | | pathy | | | | 10 Years |
| | | ner | Sequentially list conditions, if any, leading to immediate Due to (or as a consequent | nea of): | | | | | |
| | ecute and -transi | Examiner | Cause (Disease or injury that initiated events resulting in death) Last Coronary Art C. Due to (or as a consequent) | | ısease | | | | 20 Years |
| 0/00 | e be ey slcian buria | | d d | 00 017. | | | | | |
| 00 | rtificate ng phy as the | Medical | 0. | | | | | | |
| ۲ ۵ | ath cer | Physician/M | IF FEMALE: 23b. Was decedent pregnant In the past 12 months? □ 1 □ Live birth 2 □ Fetal de | eath 3 🗆 | Ectopic pregnancy | | | 23d. Date of de | lvery Day Year |
| | the de y the a | ysic | 1 □ Yes 2 □ No 9 □ Unknown 4 □ Pregnant at time of deat | h 5∐ | Other (specify) | | | | |
| Ĺ | s that ined by e deta | by Ph | Part II. Other significant conditions contributing to death but not resulting | g in the un | derlying cause give | n in Part I. | 23e. Did tobac | cco use contribute to | the cause of death? |
| cords, | equire | ted | Chronic Obstructive Pulmonary D | iseas | е | | 1 ☐ Yes | 2 No 3 Pi | obabiy 4 XUnknown |
| ב ב | Attending Physician: The law requires that the death certificate be executed at death. rector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit | Completed | | | · . | | 24a. Was an autopsy performe | d? prior to death? | topsy findings available completion of cause of |
| 0 | ctor, p | BeC | 25. Was case referred to medical examiner? | | | 26. Place of Death | 1 Yes 2 (Check only one) | INO ILIYES | 2 No |
| 5 | Physic this or al dire | 은 | 1 ☐ Yes 2☐ No Hospital: 1☐ Inpatient 2☐ ER | Outpatient | | 4 Nursing Hon | | e 6 □Other (Spe | city) |
| 5 | ding In. | tion: | 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation | Injury | 28c. Injury Work' M 1 □ Y | at ? ′es 2 ∐ No | 8d. Describe how | injury occurred | |
| 2 2 2 | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home building, etc. (Specify) | , farm, stre | et, factory, office | 2 | 8f. Location (Stree City or Town, S | et and Number or Ro State) | ıral Route Number, |
| | spital | | 29a. Certifier 1X Certifying Physician: To the best of my knowle | dge, death | occurred at the tim | e, date and place, a | and due to the caus | se(s) and manner as | stated. |
| | To the Hospital or within 24 hours afte To the Funeral Discompletely filled in | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and manner stated. | and/or inv | estigation, in my op | inion, death occurre | ed at the time, date | and place, and due | to the cause(s) |
| | | 2 | 29b. Signature and title of certifier | m | 29c. License | | | Date signed (Mont | |
| - | 30 | | 30. Name and address of person who completed cause of death (Items) | a) (Type F | 16360 | | | ovember 1 | J, ZUUb |
| | | | Dr. Samuel D. Goldberg M.D. 641 | 0 Roc | | . #200 I | Bethesda, | Md. 2081 | 7 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NOV 1 4 2006 | - Sant | W | | | | |

| Pivisician Middical Sample of the property of | | | | 1- State Registrar | e of Maryland / Dep <i>Ce</i> | ertificate of | | | 2006 | 37941 |
|--|--------|------------------------------------|---------|--|---|-----------------------|----------------------|------------------------|-----------------------------|---------------------------|
| Movember 12, 2000 Brad Properties Movember 12, 2000 Brad Prope | | Dhysia | | Decedent's Name (First, Middle, Last) | | | | 2. Date of Death | - | |
| Figure Control Contr | | | | * | | | | November | 12, 200 | 6 5:48 pm |
| Second Security Number 5 sizes | | Examir | er | | f number) | | | | | |
| Director 10 10 10 10 10 10 10 1 | | | | | 7 Age //p yrs /act hirthday | | | O Data of Birth | | |
| Unabligated and Decoders 100. Decoders 100. County | | | | 167 № 20 | = | | | (Month, Day, Y | ear) (| ountry) |
| Treval Auman Mattia Wife 115 DryGet Street, Silver Spring, MD 2001 198. Maling Address (Sweet and Number or Furni Mode). Make in Summer) 198. Informatis Name (First, Middle, Last) 198. Informatis Name (First, Middle, Max. Spring, Mid | | ס | | | | | | ripiti 20, | 2324 110 | billing coll, be |
| Treval Auman Mattia Wife 115 DryGet Street, Silver Spring, MD 2001 198. Maling Address (Sweet and Number or Furni Mode). Make in Summer) 198. Informatis Name (First, Middle, Last) 198. Informatis Name (First, Middle, Max. Spring, Mid | | arylan show | _ | 10a. State 10b. County | 10c. City, Town or L | ocation | | | | |
| Treval Auman Mattia Wife 115 DryGet Street, Silver Spring, MD 2001 198. Maling Address (Sweet and Number or Furni Mode). Make in Summer) 198. Informatis Name (First, Middle, Last) 198. Informatis Name (First, Middle, Max. Spring, Mid | | 88-f. | octo | | Silve | r Spring | | | | 1 ☐ Yes 24 ☐ No |
| Treval Auman Mattia Wife 115 DryGet Street, Silver Spring, MD 2001 198. Maling Address (Sweet and Number or Furni Mode). Make in Summer) 198. Informatis Name (First, Middle, Last) 198. Informatis Name (First, Middle, Max. Spring, Mid | | th with the | ai Dire | | | 10f. Zip Code | 20901 | 10g | | |
| Treval Auman Mattia Wife 115 DryGet Street, Silver Spring, MD 2001 198. Maling Address (Sweet and Number or Furni Mode). Make in Summer) 198. Informatis Name (First, Middle, Last) 198. Informatis Name (First, Middle, Max. Spring, Mid | | rdea | ner | | | Was Decedent of | Hispanic Origin? (Sp | pecify Yes or No- | | |
| Treval Auman Mattia Wife 118 Dryder and who completed to the course of Deposition (Name of Deposition | 36 | s afte | y Fu | If Yes | , Give | | | | | |
| Treval Auman Mattia Wife 115 DryGet Street, Silver Spring, MD 2001 198. Maling Address (Sweet and Number or Furni Mode). Make in Summer) 198. Informatis Name (First, Middle, Last) 198. Informatis Name (First, Middle, Max. Spring, Mid | 8 | hour tural | ed b | | | odent's Lisual Occur | nation | 401 | | |
| Treval Auman Mattia Wife 118 Dryder and who completed to the course of Deposition (Name of Deposition | 15 | in 72 n "na | piet | (Specify only highest grade complete | (Give | e kind of work done | during most of work | king 161 | b. Kind of Business | Vindustry |
| Physician Medical Examiner Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician South Physic | 212 | d with giene. ir tha | mo | | | Meat Cutt | er | Fo | od Servi | ce/Grocery |
| Physician Medical Examiner Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician South Physic | b | al Hyg I othe Vent, | | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Nam | e (First, Middle, Mai | den Sumame) | |
| Physician Medical Examiner Physician Medical Examiner South Control Physician Medical Examiner South Control Physician Medical Examiner South Control Physician Medical Examiner South Control Physician Medical Examiner South Control Physician Medical Examiner South Control Physician Physician Medical Examiner South Control Physician | Na | Ments Ments arkec | Tof | Carmelo Mattia | | | Angelin | a Dela Fa | ra | |
| Physician Medical Examiner Physician Medical Examiner South Control Physician Medical Examiner South Control Physician Medical Examiner South Control Physician Medical Examiner South Control Physician Medical Examiner South Control Physician Medical Examiner South Control Physician Physician Medical Examiner South Control Physician | Jar | 2 sho | 6 | 19a. Informant's Name/Relationship (Type, Print) | 19b. Mail | ing Address (Street | and Number or Rui | al Route Number, C | ity or Town, State, | Zip Code) |
| Physician Medical Examiner Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician South Physic | 2 0 | l and lealth im 27 har tr | | | | Dryden S | | | | |
| Physician Medical Examiner Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician South Physic | 20 | iges intofficers: | | 13 Burial 2 ☐ Cremation 3 ☐ Removal fr | cemetery cre | matory or other ola | cel las | | c. Location - City or | Town, State |
| Physician Medical Examiner Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician Medical Examiner South Physician South Physic | Ħ | it. Partmer intant injury | | | Bapt | ist | 200 | | rtonsvil | le, Maryland |
| Physician Medical Examiner The proposed and provided and a consequence of the proposed and provided and prov | Ba | perm Depa Impo any i | | 21. Signature Futeral Service Licensee | . 1/4 | | | | | |
| Physician Modical Examiner Physician Modical Examiner State Management Man | | | - | 23a. Part1. Enter the disease, or complications th | | | | | | |
| Mindeled Examiner Mindeled Examiner Mindeled Examiner Mindeled Examiner Mindeled Examiner Mindeled Examiner Mindeled Examiner Mindeled Examiner Mindeled Examiner Mindeled | | Dhusisian | | Immediate Cause (Final | on each line. | | | or roopilatory arrost, | | Interval Between |
| Sequentially list conditions, if any, leading to immediate cause, first Underlying and the property of the past 12 months? Sequentially list conditions, if any, leading to immediate cause, first Underlying the past 12 months? | Ì | | | disease or condition resulting in death) a. Acu | | Infarctio | n | | | 30 Minutes |
| Second Process Seco | | Examiner | | | to (or as a consequence or). | | | | | |
| The first inflated events as a consequence of): Due to (or as a consequence of): | Ι., | n = | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | to (or as a consequence of): | | | | | |
| Section Sect | | acute and trans | ami | that initiated events | | | | | | |
| 25. Was case referred to medical examiner? 1 | 60, | be excian a | Ē | Due | to (or as a consequence of): | | | | | |
| 25. Was case referred to medical examiner? 1 | 87 | physi physi the t | dica | d | | | | | | |
| 25. Was case referred to medical examiner? 1 | _ | ding rate as | /Me | | outcome of pregnancy | | | | 001.0 | |
| 25. Was case referred to medical examiner? 1 | B | death atter | ciar | in the past 12 months? | ve birth 2 Fetal death 3 | | у | | | |
| 25. Was case referred to medical examiner? 1 | o. | t the c by the achec | hysi | Tes 2010 | | | | | | |
| 25. Was case referred to medical examiner? 1 | | s tha | y P | Part II. Other significant conditions contributing to | o death but not resulting in the u | inderlying cause giv | ven in Part I. | 23e. Did tobacc | co use contribute to | the cause of death? |
| 25. Was case referred to medical examiner? 1 | īd | equire en sig | edi | Clostridium Difficile | Colitis | | | 1 🗆 Yes | 2 □ No 3 □ Pi | obabiy 4 🗷 Unknown |
| 25. Was case referred to medical examiner? 1 | 000 | aw re as bed 2 sho | piet | | | | | | 24b. Were at | utopsy findings available |
| 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 28. Date of Injury 28. Date of Injury 28. Date of Injury 28. Date of Injury 38. Date of Injury 38. Date of Injury 38. Date of Injury 38. Date of Injury 38. Date of Injury 48 | | The ate has page | mo: | | | | | performed | ? death? | |
| Address of person who completed cause of death (Item 23a) (Type, Print) The political | Ita | sian: artifica ctor, | a) | | | | 26. Place of Deat | | 10 100 | 20110 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Tannenbaum, M.D. 1145 19th Street, #303, Washington, DC 20036 | | hysic this call dire | | 1 ☑ Yes 2 ☐ No Hospital: 1 | | " 3 L DON | 4 🗆 Nursing no | me 5 Residence | 6 ☐Other (Spe | cify) |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Tannenbaum, M.D. 1145 19th Street, #303, Washington, DC 20036 | Z Z | ing P | on: | | | Wor | | 28d. Describe how in | njury occurred | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Tannenbaum, M.D. 1145 19th Street, #303, Washington, DC 20036 | S | tend death tor: / the f | icat | 2 □ Could not be | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Tannenbaum, M.D. 1145 19th Street, #303, Washington, DC 20036 | 2 | after Dirac in by | ertif | determined 200. Fl | ace of injury - At nome, farm, sti uilding, etc. (Specify) | reet, factory, office | | City or Town, Si | t and Number or Ri late) | ıral Route Number, |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Tannenbaum, M.D. 1145 19th Street, #303, Washington, DC 20036 | | spita iours neral filled | | 29a. Certifier 1X Certifying Physician: To | the best of my knowledge deat | h occurred at the tir | me date and place | and due to the course | a(s) and manner as | Stated |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Tannenbaum, M.D. 1145 19th Street, #303, Washington, DC 20036 | | na Ho | dic | (Check only 2 Medical Examiner: On th | e basis of examination and/or in | vestigation, in my o | pinion, death occurr | ed at the time, date | and place, and due | to the cause(s) |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Tannenbaum, M.D. 1145 19th Street, #303, Washington, DC 20036 | | To th withir To th comp | Me | 29b. Signature and title of certifier | 1 10 | 29c. Licens | e number | 29d. | Date signed (Mght | h, Day, Year) |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Tannenbaum, M.D. 1145 19th Street, #303, Washington, DC 20036 | | 1 | | hal law | John F | DS IN | 0772 | // | 1/12/0 | 6 |
| | | V | | 30. Name and address of person who completed of | ause of death (Item 23a) (Type, | Print) #20 | 2 57- 1 : | | 00000 | , |
| State Registrar State NOV 1 4 2006 | | | | • | 4. | теет, #30 | o, washin | gton, DC | 20036 | |
| | ** | | | 31. Date filed (Month, Day, Year) NOV 1 4 2006 | Registrar's Signature | de | | | | |

| ian | DHETTY D. | Minor | | | | · | | | | 2. Date of D Month Novemi | Da | y ` | Year | Time of Death |
|------------------|---|-----------------------------------|--------------------------|---|--------------------------|---------------------------|--------------------|-------------------|--------------|---------------------------------|--------------------------|-------------|---------------------------------------|------------------------------------|
| cal ner | The control of the c | ion, give stree | t and num | ber) | | 4b. City, | Town, or | Location of | of Death | Novemi | | . County of | | 3:37 ™ |
| | Shady Grove A | dventis | t Ho | spital | | Rocl | kvil | le | | | | Mont | gomery | 7 |
| | 5. Social Security Number 577-80-3987 | 6. Sex 1 ☐ M | | | . last birthday) Yrs. | If Under Months | 1 Year Days | If Under Hours | Min. | 8. Date of B (Month, D | av. Year) | | 9. Birthplace Country) | (State or Foreign |
| | Usual Residence of Decedent | | | 50 | Trs. | | | | | Oct. 5 | , 19 | 56 W | ashing | ton, DC |
| | 10a. State 10b. Cour | , | | 10c. C | ity, Town or La | | | | | | | | 10d. i | nside City Limits |
| ctor | Maryland Mont | gomery | | | Rockvi | ille | | | | | | | 1 | X Yes 2 □ No |
| Funeral Director | 10e. Street and Number 7909 Coriande | . J. j | #201 | 2 | | 10f. Zip | | 20879 | | | - | | nat Country? | |
| era | 11. Marital Status | | | lent Ever in t | 19 13 1 | Nas Decod | | | | acifu Vac as N | | | State American Ir | |
| | | arried 1 | med Ford | es? DXINo | ' | | | n, Mexican | n, Puerto | ecify Yes or N Rican, etc.) | 0- | | White, etc. | |
| A P | 3 ☐ Widowed 4 ☐ Divord | ed Y | Yes, Give 'ear or Dat | es: | | 1□Yes 2 | 2KM No | Specify: | | | | Specify: | Blac | K |
| Completed | 15. Deced (Specify only hig | ent's Education nest grade con | n npleted) | | 16a. Deced (Give | kind of wor | rk done d | lurina most | t of work | ing | 16b. K | ind of Busi | ness/Industr | у |
| amo | Elementary/Secondary (0-12 |) C | ollege (1-4 | for 5+) | | nploye | |) | | | 1 | None | | |
| Be Co | | e, Last) | | | T OHOL | приоде | | 18. Mothe | r's Name | First, Middle | J | | | |
| To B | Thomas F. F | rederic | k | | | | | | E | velyn | Min | nor | | |
| | 19a. Informant's Name/Relation Michelle Mino | | | | 19b. Mailin 5400 (| g Address (uail | (Street a | ek Ct | or or Rura | al Route Numb aleigh | er, City o | r Town, St | ate, Zip Cod | ie) |
| | 20a. Method of Disposition | | | | Place of Disport | sition (Nam | ne of | 9) | | Date | 20c. Lo | cation - Ci | ty or Town, | State |
| | 1 ☑ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other | | al from St | | mony M | | | | ov. I | 14, 2006 | Lar | ndove | r, Md. | |
| | 21. Signature of Funeral Service | Licensee | , ~ | 01085 | 22 | . Name and | d Addres ¶arll | s of Facility | y Po Pike | pe Fun ; Fore | eral stvi | Home. | s Md. 2 | .0747 |
| | 23a. Part 1. Enter the disease, shock, or heart failure. | or complication | ns that cau | used the dea | th. Do not ente | er the mode | of dying | g, such as | cardiac c | or respiratory a | ırrest, | | | roximate rval Between |
| | Immediate Cause (Final disease or condition | | | nock | | | | | | | | | | et and Death |
| | resulting in death) | (| Due to (or | as a consec | | | | | | | | | | |
| - | Sequentially list conditions, | b | | espira | tory/Ca | rdia | c Ar | rest | | | | | | |
| Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | ≺ _ | | | ry Embo | lus | | | | | | | | |
| Exa | that initiated events resulting in death) Last | c | | as a consec | | | | | | | | | | |
| dlcal | 1 | d | Co | ongest | ive Hea | ert Fa | ailu: | re | | | | | | |
| Physician/Me | IF FEMALE: 23b. Was decedent pregnant | | | me of pregn | | | | | | | | 23d. Date o | of delivery | |
| SICIS | in the past 12 months? 1 ☐ Yes 2 ☒ No | 4 | | h 2∏ Feta it at time of c | | Ectopic pre Other (spe | | <u>-</u> | | | | Month | | Year |
| Ę | 9 Unknown | | | | | | | | | | | | | |
| à p | Part II. Other significant condi | uons contribut | ing to deal | in but not res | suiting in the un | derlying ca | use give | n in Part I. | | | | | | use of death? |
| Completed | | | | | | | | | | 10 | 192 | | | 4 🖄 Unknown |
| d E C | | | | | | | | | | 24a. Was auto | | 24b. Wei | re autopsy fi r to completi th? | ndings available on of cause of |
| ø | 25. Was case referred to medic | al | | 7) 2.0 | | | | 06 Dia | -4 D45 | 1. Yes | 235 No | 10 | Yes 2□1 | |
| 0 | examiner? 1 ☐ Yes 2 ☒ No | Hospita | al: 1 (Ž Inp | atient 2 🗆 | ER/Outpatient | 3 DO | Othe | _ | | Check only one 5 Resi | | S □Other / | (Specify) | |
| | 27. Manner of Death 1 XNatural 5 Pend | 288 | | Injury Day Year) | 28b. Time of Injury | | lc. Injury Work | | | 28d. Describe | | | <i>эрвену</i>) | |
| cat | | tigation | | | | М | 1 🗆 Y | es 2□N | 10 | | | | | |
| Certification: | | mined 286 | e. Place of building | Injury - At h. , etc. <i>(Specit</i> | ome, farm, stre | et, factory, | office | | 2 | 28f. Location (City or To | Street and vn. State) | Number of | or Rural Rou | te Number, |
| <u>_</u> | 29a. Certifier 1 🕱 Certify (Check only one) | r Examinier. | ın ihe bası | s of examina | wiedge, death | occurred a | t the time | e, date and | l place, a | and due to the | cause(s) | and manne | er as stated. | ause(s) |
| Medic | 29b. Signature and title of certif | al al | nd manner | stated. | | | License | | | | | | Month, Day, | |
| | 1 10 | . 1 | 1. | | | | | 4-6 | 15 | | | | - | |
| | 30. Name and address of person | n who complete | ed cause of | of death (Iten | n 23a) (Type, P | | $\omega \iota$ | | 1 -> | | 11 1 | 9100 | 0 | |
| | | cisse, | | | Medica | | | - | - | | | 208 | | |

| | | 1 - For State Registrar | State of Ma | ryland / Depa | artment of F rtificate of | | d Mental Hy | giene Reg. No. | 006 | 3794 |
|--|---------------------|---|--|--|--|-----------------------------|---|--------------------------------|--|--|
| Physic /Med Exam | ical | Daniel Magrue As Facility Name (If not institution, give | der | | 4b. City, Town, c | or Location of D | | er 05, | Year 2006 unty of Death | 3. Time of Dea 7:09 A |
| Funera | ۲ | Prince George's 5. Social Security Number 6. Se | | pital (In yrs. last birthday) 75 Yrs. | Chever1 If Under 1 Year Months Days | If Under 24 I | Hrs. 8. Date of Bir Ain. (Month, D) July 23 | rth | 9 Birthp | rge's lace (State or Fo. try) ngton D(|
| Maryland -f ehow | | 577-40-9261 Usual Residence of Decedent 10a. State 10b. County District of Column | | 10c. City, Town or Lo Washingto | | | pury 23 | 0,1931 | | Od. Inside City Li |
| th with the 23a or 28a let be not | Funeral Director | 10e. Street and Number 3816 2nd Street Ap | | washingto | 10f. Zip Code 20032 | | | - | of What Coun | try? |
| ine, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Ie marked other than "natural", or Items 28a or 28a-f show other traumatic event, the Medical Examiner must be marified at | þ | 11. Marital Status 1 Never Married 2 Married 3 Widowed Married | 12. Was Decedent E Armed Forces? 12€ Yes 2 □ N If Yes, Give Year or Dates: | 0 | f Yes, specify Cubi | an, Mexican, Pu | ? (Specify Yes or No uerto Rican, etc.) | Spe | Race - Americ Black, White, o | etc. |
| nd 21215-0036 Miled within 72 hours all Hygiene. I other than "natural", or vent, the Madical Exami | • Completed | 15. Decedent's Edil (Specify only highest grac Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) | cation le completed) College (1-4or 5- | (Give | lent's Usual Occup kind of work done DO NOT use retired ity Offic | during most of d) CET | | U.S.De Interi | | |
| Maryland d 2 should be file th and Mental Hy t7 le marked oth traumatic event | To Be | Daniel Magruder 19a. Informant's Name/Relationship (T) | one Print! D | 105 14:15 | | Hi1da | Cooper | | | |
| Baltimore, Ma bernit. Peges 1 and 2 s Department of Health an mportent: If them 27 le. my jojury or other trauu page. | | Elizabeth Magruder 20a. Method of Disposition 1 Strain 2 Cremation 3 F 4 Donation 5 Other (Specify) | Williams | / 22 At | Lantic St sition (Name of natory or other place | Nov | #12 Washir Date ember 14, | ngton, 20c. Location | D. C. 20 | 0032 wn, State |
| Baltimore permit. Peges: Department of the tmportsnt: If ite any injury or of | | 21. Signature of Funeral Service Licens | | 22 | . Name and Addre | ss of FacilityR | Obert G.] SE, Wash | Mason | gle,Vi Funeral | Home T |
| orte be executed year be executed by sician and the burial-transit the burial-transit and t | dical Examiner | disease or condition resulting in death) Sequentially list conditions, if day, leading to minimulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a b. Sepsis Due to (or as a | consequence of): | 110vascu. | Lar D1se | ease | | | |
| fro. Box b8/bu, that the death certificate be executed ed by the attending physician and detached for use as the burial-transit | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | l3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown | Fetal death 3 | Ectopic pregnancy Other (specify) | , | | | Date of deliver Month | y Day Year |
| he law requires that has been signed be age 2 should be deta | ompleted by Pr | Part II. Other significant conditions con End Stage Renal D Pericardial Effus | isease; Mu | | | | | Yes 2□No | 3 ☐ Proba | cause of death? |
| _ 66 | e Comp | 25. Was case referred to medical | | | | | autop perfo 1 Yes | osy rmed? 2 No | prior to com death? | pletion of cause |
| on or ding Phy h. After this funeral d | Certification: To B | examiner? 1 Yes 2 No 27. Manner of Death 1 Notatural 5 Pending 2 Accident investigation | lospital: 1 Inpatien 28a. Date of Injury (Month, Day | 28b. Time of | 28c. Injun Worl | er: 4 🗆 Nursing | Death Check only on the property of the prope | dence 6 🗆 0 | |) |
| DIVISIC pitel or Attencours effer death erel Director: filled in by the | | 3 Suicide 6 Could not be 4 Homicide determined | building, etc. | | | | 28f. Location (5 City or Tou | vn, State) | | |
| To the Hospitel or Attention within 24 hours effer deat To the Funerel Director: completely filled in by the | Medical | 29a. Certifier 1文 Certifying Physical Control 2 Medical Examination 29b. Signature and title of certifier | sician: To the best of | my knowledge, death examination and/or inv ad. | occurred at the timestigation, in my operation of the control of t | pinion, death oc number | ccurred at the time, | date and plac 29d. Date sig | manner as state, and due to ned (Month, Der 8,20 | the cause(s) |
| - (2) | 18 | 30. Name and address of person who co | | | | erly, Ma | aryland 2 | 0785 | | |
| St Regist | | 31. Date filed (Month, Day, Year) NOV 1 5 2006 | 32. Registrar | 's Signature | , | | | | | |

| | | - | For State Registrar | tate of Marylan | | partmen <i>ertificat</i> | | | | giene Reg. No. | 006 | 37944 |
|-------------------|---|------------------|---|--|--------------------|--|-------------------------|--------------------------------------|---|---------------------|--------------------------|--|
| | Physicia | | Decedent's Name (First, Middle, Last) | mcCar | -100 | , | | | 2. Date of Dea Month | Dav | Year | 3. Time of Death |
| 1 | /Medic Examin | al | Fannie L 4a. Facility Name (If not institution, give stree | | 100 | 1 | Town, or Lo | cation of Death | 11 | 08 4c. C | ounty of Deat | h |
| | LAGIIIII | | Coastal Hospice a | | _ | Sa | | Under 24 Hrs. | | | | mico |
| Н | Funeral Director | | 5. Social Security Number 6. Sex 1 M | 7. Age (In yrs. 88 | nast birtna Yrs | Months | | Hours Min. | 8. Date of Birt Month, Day 8/30/1 | 918 | Nort | hplace (State or Foreign unitry) Carolina |
| | σ | | Usual Residence of Decedent 10a. State 10b. County | 10c. Cit | y, Town o | r Location | | | | | | 10d. Inside City Limits |
| | Manyla -1 sho | to | Maryland Wicomico | | | tland | | | | | | 1K∑Yes 2 ☐ No |
| | or 28s | Direc | 10e. Street and Number | | | 10f. Zig | | | | • | on of What Co | ountry? |
| | eath w | Funeral Director | 107 Covered Bridge 11. Marital Status 12. 1 | Lane Was Decedent Ever in U. | .s. | | 21826 dent of Hispa | anic Origin? (Spe Mexican, Puerto | cify Yes or No | US | . Race - Ame | |
| 920 | be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show adother than "natural", or items 23a or 28a-f show swent, the Madical Examinar must be notified at | þ | 1 Never Married 2 Married | Armed Forces? I □ Yes 2 X No If Yes, Give Year or Dates: | | If Yes, spe | | Mexican, Puerto | Rican, etc.) | 1 | Black, Whit | e, etc. hite |
| 21215-0036 | n 72 hc "natur | Completed | 15. Decedent's Education (Specify only highest grade co | mpleted) | 1 (6 | ecedent's Usu Give kind of wo fe. DO NOT u | ork done duri | n ing most of worki | ng | 16b. Kind | d of Business | Industry |
| 212 | e filed within at Hygiene. I other then " | omo | Elementary/Secondary (0-12) | College (1-4or 5+) | | memake | | | | Dor | nestic | |
| pu | be filed htal Hygi ed other svent, I | Be | 17. Father's Name (First, Middle, Last) Roswell Blackmon | | | | 18 | B. Mother's Name Pydie | , | Maiden S | umame) | |
| Maryland | should be nd Mental marked o | ဥ | 19a. Informant's Name/Relationship (Type, | Print) | | | | Number or Rura | l Route Numbe | | | |
| | od 2 lith a 27 is r tra | | Pyda L. Sterling/da | _ | _ | | | Bridge L | | | | |
| Baltimore, | 0 0 | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remode 4 □ Donation 5 □ Other (Specify) | oval from State | emetery, | isposition (Na crematory or c ew Ceme | other place) | | 3/06 | | ation - City or Mount | |
| Balt | permit. Page Department of Important: if any injury or once. | | 21. Signature of Funeral Service Dicensee **Real Range Dicensee** | o CFSP | | Hollo 501 S | way Fi now H | ineral H | ome Pro Salisb | fess: oury, | ional A MD 218 | Association 304 |
| | | | 23a. Part1. Enter the disease, or complication shock, or heart failure. List onty one complications of the mediate Course (Final Inc.). | ons that caused the deat ause on each line. | h. Do not | enter the mo | de of dying, s | such as cardiac o | r respiratory ar | rest, | | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | Quelo vas a conseq | | - PR | ude | nt | | | | |
| | Examiner | _ | Sequentially list conditions, if any, leading to immediate | Alabeine | 2/5 | 1325 | merc | | | | | |
| | d ansit | mlner | frany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a conseq | uerice or) | | | | | | | |
| Ö, | icate be executed physicien and s the burial-transit | i Examin | resulting in death) Last | Due to (or as a conseq | juence of) | | | | | | | |
| 68760, | | dicai | d | | | | | | | | | |
| .O. Box (| it the death certifii by the attending p tached for use as | Physician/Me | in the past 12 months? | If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of o 9 Unknown | al death | 3 ⊟Ectopic p 5 □ Other (s | | | - AFORM | 23 | d. Date of de Month | ivery Day Year |
| <u>a</u> | \$ 6 € | by Ph | Part II. Other significant conditions contrib | uting to death but not res | sulting in th | ne underlying | cause given i | in Part I. | | | , | the cause of death? |
| ord | law requires as been sign 2 should be | | | | | | | | 10 | | - 100 A | robably 4 Unknown |
| of Vital Records, | The ate h page | Completed | | | | | - | | 1 ☐ Yes | sy rmed? 2 No | prior to death? | utopsy findings available completion of cause of |
| V. | Physician: this certific ral director, | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | pital: patient 2 |] ER/Outp | atient 3 D | Other | 6. Place of Death | | | □Other (Spe | ocify) |
| | | on: T | 27. Manner of Death Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Tin Inju | ne of | 28c. Injury at Work? | | 28d. Describe I | now injury | occurred | |
| Division | r Attender ter deatlingter the | Certification: | 2 Accident investigation | 28e. Place of Injury - At h building, etc. (Speci | | M n, street, facto | | s 2 No | 28f. Location (. City or To | | Number or R | ural Route Number, |
| | To the Hospital of within 24 hours of To the Funeral D completely filled in | | 29a. Certifier Check only Medical Examiner | an. To the best of my kn.: On the basis of examina | wiedge i | death onnuma | f at the time. | date and water | and due to the | causa(s) a | and manner a | s stated |
| | the Hohin 24 ths Fu | Medical | one) 29b. Signature and title of ceptifier | and manner stated. | | | C. License n | | ed at the talle, | | | th, Day, Year) |
| | or with | | Signature and into accoming | Ano |) | | | | 3 | | | |
| _ | 600 | | 30. Name and address of person who comp | IMS Cost | of H | ype, Print) | po, | Box 173 | 73 5 | olish | mo | 71802 |
| | Sta Registi | | NOV 1 3 200 | 32. Registrar's Sign: | ature | Mars | | | | |)′ | |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 21, Mallery 2006 9:00 A M Lvdia 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Jul 27, 9. Birthplace (State or Foreign Country)
DE 1 □ M 2 🗐 F 215-56-7863 95 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Allegany MD Cumberland 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 229 Baltimore Avenue Apt 903 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 □ Yes 2 □ **X**o Specify: 3 ☑ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Allegany Co. School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry K. Ely Elsie Billingsley Ely 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Offutt Street Edith Abbott daughter Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/25/2006 **Davis Memorial Cemetery** MD 4 □ Donation 5 □ Other (Specify) Cumberland 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a End stage kidney disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D14865 November 22, 2006

/Medical Examiner sician and burial-transit Division or Vital Records, P.O. Box 68760, After this s after death To the Hospital c within 24 hours af To the Funeral D

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ms 23a or 2

"natural", or items

event, the Medical

...d fy...
... 1 and 2 should be ...d of Health and Merant: if item 27 is r...
.ry or other tr

permit. Page Department o Important: If any injury or

Physician

Director

Funeral

Completed by

Be

Examiner

Completed by Physician/Medical

Be

Certification: To

Medical

ould be filed within 72 hours after death with the Maryland Mental Hygiene.

Baltimore, Maryland 21215-0036

page 2 s the filled in by completely

> State Registrar

31. Date filed (Month, Day, Year) NOV 2 9

Dr. R. Barrera, Johnson Heights Medical Bldg., Cumberland, MD 21502 32 Registrar's Signature 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 06 37946 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day William Marshall 91 0435 00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Lamts-Braddock Campus umberland ALLEGAN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/29/23 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) t**y** M 2□ F Director Yrs. WV 231-44-7489 Usual Residence of Decedent 83 the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits er than "naturel", or Itame 23s or 28s-f show the Madical Examinar must be notified at Directo Mineral New Creek 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26743 U.S.A. HC 75, Box 97 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 1-☑Yes 2 ☐ No If Yes, Give Year or Dates:WW∏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2√€ No þ Specify: Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) Chief Aviation Machinist 12th U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental William W. Marshall Lillie Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 itam other tre Ida Marion Marshall HC 75, Box 97, New Creek, WV 26743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Himportent: If its any injury or of 2005 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Knobley Cemetery 11/25/06 Antioch, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Markwood Funeral Home, Inc. P.O. Box 912, Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PROSTATE CANCER 16TASTASTATIC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 25 NO 1 Tyes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cete has page 2 s autopsy certificate Vital 1 ☐ Yes 🎢 No Attending Physician: After this certification Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) BE No Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Division of 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No Director: , d in by the f 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ō within 24 hours e To the Funeral C completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10063462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - 902 Seton DRIVE Cumberland, Md 21502 DR. Alida Hodrumar 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 2 9

State of Maryland / Department of Health and Mental Hygier 0 0 5 37947 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Joel Larry Miller November 19, 2006 9:37 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death McCready Memorial Hospital Crisfield Somerset 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Feb. 8, Birthplace (State or Foreign Country) 1**X**M 2□F Director 198-28-3235 71 Yrs. Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County item 27 is marked other then "naturel", or items 23e or 28a-f show other treumatic event, the Madical Examinat must be notified at 10d. Inside City Limits PA York Glen Rock Directo 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2224 Valley Road death 17327 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 X Yes 2 No If Yes, Give Year or Dates:1955-58 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 M Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life, DO NOT use retired)
TOOL & Die Maker 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Precision Tool Co. 12 Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Fissel Miller Carrie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lindy L. Sweeney/Daughter 707 Strawberry Rd., New Freedom, PA 17349 Date 24, 20b. Place of Disposition (Name of cometery, crematory, or other p New Freedom Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State Nov. permit. Page Department (Importent: If eny injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) New Freedom, PA 2006 21. Signature of Funeral/Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. frell 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) **Examiner** ASCVD Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or do a consequence or) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed physician and sthe burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death P.O. 5 Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Records, þ page 2 should Be Completed 3 Probably 4 Winknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Division of Vital 1□ Yes 1 ☐ Yes 2 ☐ No director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Alatural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the the 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) D 48098 2006 201 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijay Karumbunathan, M.D. 🐠 - 201 Hall Highway - Crisfield, MD 21817 2006 32. Projetrar's Signature Registrar

| | | | For State of Maryl | | artment of H rtificate of I | | | 000 | 16 2701.0 |
|-------------------------------|---|--|--|--|---|---|---|--|---|
| | g | | Registrar 1. Decedent's Name (First, Middle, Last) | | Timeate of I | Jean | 2. Date of Deal | eg. No. | 3. Time of Death |
| | Physici /Medio | | Robert Henry M | alin | | | Novembe | r 19 20 | Year 006 1313 PM |
| | Examin | | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or | Location of Death | | 4c. County of | |
| | | | Union Hospital | | E1kton | | | Ceci | 1 |
| в | Funeral Director | | 1 TtM 2 T E | yrs. last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | Date of Birth (Month, Day, | Year) | Birthplace (State or Foreign Country) |
| Ļ | | | 189-16-8143 TXM 2 82 Usual Residence of Decedent | 113. | | | FEB 5, 1 | 1924 | Pennsylvania |
| | how | | 10a. State 10b. County 10c. | . City, Town or Lo | ocation | - | | | 10d. Inside City Limits |
| | 8a-fs | Director | | Rising S | Sun | | | | 1 X Yes 2 □ No |
| | with ti | Dire | 100 M N | 007 | 10f. Zip Code | | 1 | 0g. Citizen of Wh | nat Country? |
| | ns 23 | eral | 100 McNamee Lane, Apartment 11. Marital Status 12. Was Decedent Ever in | | 21911 | ispania Origin? (Spo | oifu Voc or No | | States - American Indian, |
| 9 | or Iten | by Funeral | Armed Forces? 1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 ☐ 📆 No | 1 | | spanic Origin? (Spe n, Mexican, Puerto | Rican, etc.) | | White, etc. |
| 003 | within 72 hours after death with the Maryland ene. Itan "ratural", or Items 23a or 28a-f show ite Mardical Examinar must be notified a | d by | 3 Widowed 4 Divorced If Yes, Give Year or Dates: | | 1 ☐ Yes 2 💢 No | Specify: | | Specify: | White |
| <u>5</u> -(| "natu | Completed | 15. Decedent's Education (Specify only highest grade completed) | 16a. Deced (Give | ient's Usual Occupa | ation furing most of workii) | ng | 16b. Kind of Busi | ness/Industry |
| 72 | withir ene. than | dmo | Elementary/Secondary (0-12) College (1-4or 5+) | | po <i>nor us</i> a ratirad porer |) | | M C | |
| 0 | filed I Hygi othar ant, | Be Co | 17. Father's Name (First, Middle, Last) | | orei | 18. Mother's Name | | Manufac Maiden Sumame) | |
| /lar | uld be Menta Irked Itic ev | To B | Benjamin Malin | | | Catheri | ne Ander | son | |
| lar, | uges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Menth Hygiene. If file in 27 is marked other trans "natural", or items 23a or 28a-1 show if file in 27 is marked other transmit. The Marical Examinating marked be notified at | | 19a. Informant's Name/Relationship (Type, Print) | | | und Number or Rura | | | |
| e) | 1 and 4ealth 9m 27 thar t | | Gladys Malin/Wife 20a. Method of Disposition 20i | | | | | | , MD 21911 |
| altimore, Maryland 21215-0036 | permit. Pages 1 and 2 Department of Health ar Important: If item 27 is any injury or other trace | | A Banki E Coloniation o Chambrainon State | | sition (Name of natory or other place | | ber | | ity or Town, State |
| | artme ortan injury | | `4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee | | Cemetery | 22, 20 | 006 P | ort Depo | osit, MD |
| B | permit. Departr Importe any inju | | March & Hickory | Hi | cks Home | for Fune | rals, P. | A. | ryland 21921 |
| | | | 23a. Part1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line. | eath. Do not ente | er the mode of dying | g, such as cardiac o | r respiratory arre | st, | Approximate Interval Between |
| H | Physician | | | n cotton | . Mist | Nosa 5 | mdron | .0 | Onset and Death |
| | /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) a. Aute les | | 7 0.0 | | 1 | | |
| | | in line | Sequentially list conditions, b. Preumo | | | | | | Zweells |
| T | uted d ansit | Examiner | Sequentially list conditions. Tarry, leading to immodate cause. Enter Underlying Cause (Disease or injury that initiated events C. | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | |
| o V | an an | | resulting in death) Last Due to (or as a cons | sequence of): | | | | | |
| | cate be executed thysician and the burial-transit | dical | d | | | | | | |
| 8760, | ig d s | | | | | | | | |
| x 6876 | ding ding se as | Me | IF FEMALE: | | | | | | |
| Box 6876 | eath certi attending for use a | clan/Me | 23b. Was decedent pregnant in the past 12 months? | etal death 3 🗌 | Ectopic pregnancy | | | 23d. Date of | |
| | the death certificate be executed by the attending physician and ached for use as the burial-transit | hysiclan/Me | 23b. Was decedent pregnant 23c. If yes, outcome of pre- | etal death 3 🗌 | Ectopic pregnancy Other (specify) | | | | |
| О | | Physiclan/Me | 23b. Was decedent pregnant in the past 12 months? 1 | etal death 3 ☐ of death 5 ☐ resulting in the un | Other (specify) | n in Part I. | 23e. Did tob | Month | |
| О | es that the igned by th be detache | by Physiclan/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | etal death 3 ☐ of death 5 ☐ resulting in the un | Other (specify) | n in Part I. | 23e. Did tobi | Month | Day Year |
| ecords, P.O | es that the igned by th be detache | by Physiclan/Me | 23b. Was decedent pregnant in the past 12 months? 1 | etal death 3 ☐ of death 5 ☐ resulting in the un | Other (specify) | n in Part I. | 1 ☐ Yes 24a. Was an | Month acco use contribut s 2 No 3 | Day Year ute to the cause of death? Probably 4 □Unknown re autopsy findings available or to completion of cause of |
| l Kecords, P.O | The law requires that the ate has been signed by the page 2 should be detache | Completed by Physiclan/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not in the past 12 months? CORONARY | etal death 3 ☐ of death 5 ☐ resulting in the un | Other (specify) | n in Part I. | 1 Yes | Month acco use contributes 2 No 3 (24b. We prior dea | Day Year ute to the cause of death? Probably 4 □Unknown re autopsy findings available or to completion of cause of |
| Vital Records, P.O | The law requires that the ate has been signed by the page 2 should be detache | Be Completed by Physiclan/Me | 23b. Was decedent pregnant in the past 12 months? 1 | resulting in the un | Other (specify) | 26. Place of Death | 1 Yes 24a. Was an autopsy perform 1 Yes 2 | Month acco use contribution of the contributi | Day Year ute to the cause of death? Probably 4 □Unknown re autopsy findings available or to completion of cause of th? Yes 2 □ No |
| of Vital Records, P.O | hysician: The law requires that the this certificate has been signed by the director, page 2 should be detached. | To Be Completed by Physiclan/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not leave the composition of the comp | resulting in the un Colored EP/Outpatient 28b. Time of | Other (specify) | 26. Place of Death | 1 Yes 24a. Was an autopsy perform 1 Yes 2 | Month acco use contribute a 2 No 3 24b. We prior dea dea dea dea dea dea dea dea dea dea | Day Year ute to the cause of death? Probably 4 Unknown re autopsy findings available or to completion of cause of th? Yes 2 No |
| of Vital Records, P.O | hysician: The law requires that the this certificate has been signed by the director, page 2 should be detached. | To Be Completed by Physiclan/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not examiner? 1 Yes No Hospital: | resulting in the un Colored EP/Outpatient 28b. Time of | other (specify) Identying cause give Si 5 Othe 28c. Injury Work | 26. Place of Death | 1 Yes 24a. Was an autopsy perform 1 Yes 2 (Check only one in 5 Resider | Month acco use contribute a 2 No 3 24b. We prior dea dea dea dea dea dea dea dea dea dea | Day Year ute to the cause of death? Probably 4 Unknown re autopsy findings available or to completion of cause of th? Yes 2 No |
| IVISION Of VITAI Records, P.O | r Attanding Physician: The law requires that the ter death. The transport Attenthis certificate has been signed by the by the funeral director, page 2 should be detachen by the funeral director, page 2 should be detachen | To Be Completed by Physiclan/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not in the past 12 months? 25. Was case referred to medical examiner? 1 Yes No Hospital: | resulting in the un CONTROL EP/Outpatient 28b. Time of Injury thome, farm, stre | other (specify) Identying cause give Si 5 28c. Injury Work: M 1 Y | 26. Place of Death f 4 □ Nursing Hom at 2 es 2 □ No | 24a. Was an autopsy perform 1 Yes 2 (Check only one 5 Resider 8d. Describe how | Month acco use contributes 2 No 3 24b. We prior dea 1 1 1 24b. We prior dea 1 24b. We prior dea 1 24b. We prior dea 2 24b. We prior dea 3 24b. We prior dea 3 24b. We prior dea 3 24b. We prior dea 4 | Day Year ute to the cause of death? Probably 4 Unknown re autopsy findings available or to completion of cause of th? Yes 2 No |
| IVISION Of VITAI Records, P.O | r Attanding Physician: The law requires that the ter death. The transport Attenthis certificate has been signed by the by the funeral director, page 2 should be detachen by the funeral director, page 2 should be detachen | Certification: To Be Completed by Physiclan/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not examiner? 1 Yes No Hospital: | resulting in the un Compared to the second of the second | other (specify) Identying cause give Si S 28c. Injury Work M 1 Y Pet, factory, office | 26. Place of Death 1 Unursing Hom at 2 es 2 No | 24a. Was an autopsy perform 1 Yes 2 (Check only one see 5 Resider 8d. Describe how city or Town, | Month acco use contribut a 24b. We prio dea 1 | Day Year ute to the cause of death? Probably 4 □Unknown re autopsy findings available or to completion of cause of th? IYes 2 □ No (Specify) or Rural Route Number. |
| IVISION Of VITAI Records, P.O | r Attanding Physician: The law requires that the ter death. The transport Attenthis certificate has been signed by the by the funeral director, page 2 should be detachen by the funeral director, page 2 should be detachen | Certification: To Be Completed by Physiclan/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not in the past 12 months? 25. Was case referred to medical examiner? 1 Yes No Unknown 26. If yes, outcome of president 2 1 Pregnant at time of 9 Unknown 27. Was case referred to medical examiner? 1 Yes No No Unknown 28a. Date of Injury (Month, Day Year, Month, Day Year, Month Day Year, | resulting in the un Compared to the service of the | other (specify) Identying cause give Si 5 28c. Injury Work: M 1 Y | 26. Place of Death 4 \(\text{Nursing Hom} \) at 2? es 2 \(\text{No} \) | 24a. Was an autopsy perform 1 Yes 2 (Check only one so Section (Street, City or Town, and due to the call | Month acco use contributes 2 No 3 (24b. Weber 1) acco 6 Other (20) acco 6 Other (20) acco 10 Other (20) acco | Day Year ute to the cause of death? Probably 4 Unknown re autopsy findings available or to completion of cause of th? Yes 2 No (Specify) |
| IVISION Of VITAI Records, P.O | r Attanding Physician: The law requires that the ter death. The transport Attenthis certificate has been signed by the by the funeral director, page 2 should be detachen by the funeral director, page 2 should be detachen | To Be Completed by Physiclan/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not examiner? 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: | resulting in the un Compared to the service of the | other (specify) Identying cause give Si 5 28c. Injury Work: M 1 Y | 26. Place of Death 4 \(\) Nursing Hom at 2? es 2 \(\) No 2 a, date and place, and place, and place, and place, and place, and place and place and place and place. | 24a. Was an autopsy perform 1 Yes 2 (Check only one se 5 Resider 8d. Describe how city or Town, and due to the cau d at the time, dai | Month acco use contributed and set and Number of State) Month acco use contributed and set and Number of State) | Day Year ute to the cause of death? Probably 4 Unknown re autopsy findings available or to completion of cause of th? Yes 2 No (Specify) |
| IVISION Of VITAI Records, P.O | he Hospital or Attanding Physician: The law requires that the in 24 hours affect of eath. After this certificate has been signed by the Funeral Director. After this certificate has been signed by the pietely filled in by the funeral director, page 2 should be detached. | edical Certification; To Be Completed by Physiclan/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not in the past 12 months? 25. Was case referred to medical examiner? 1 Yes 2 No No Hospital: | resulting in the un Compared to the service of the | other (specify) Identying cause give Si 5 28c. Injury Work: M 1 Y Pet, factory, office occurred at the time estigation, in my opi | 26. Place of Death 4 Nursing Hom at 2? es 2 No 2 a, date and place, annion, death occurre | 24a. Was an autopsy perform 1 Yes 2 (Check only one see 5 Resider 8d. Describe how city or Town, and due to the caud at the time, dai | Month acco use contributes 2 No 3 24b. We prio dea 1 10 | Day Year ute to the cause of death? Probably 4 Unknown re autopsy findings available or to completion of cause of th? If Yes 2 No (Specify) Or Rural Route Number. er as stated. |
| IVISION Of VITAI Records, P.O | r Attanding Physician: The law requires that the ter death. The transport Attenthis certificate has been signed by the by the funeral director, page 2 should be detachen by the funeral director, page 2 should be detachen | edical Certification; To Be Completed by Physiclan/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not examiner? 25. Was case referred to medical examiner? 1 Yes No Hospital: | resulting in the un Clere ER/Outpatient 28b. Time of Injury thome, farm, strescify) thome, farm, strescify) thome and/or invented and the control of the co | other (specify) Identying cause give Si S 28c. Injury Work 1 Y Let, factory, office coccurred at the time estigation, in my opi 29c. License | 26. Place of Death 4 Nursing Hom at 2? es 2 No 2 a, date and place, aninon, death occurre | 24a. Was an autopsy perform 1 Yes 2 (Check only one see 5 Resider 8d. Describe how city or Town, and due to the caud at the time, dai | Month acco use contributes 2 No 3 24b. We prior dea 1 24b. We prior dea 1 31ce 6 Other (av injury occurred set and Number of State) use(s) and manne e and place, and d. Date signed (A | Day Year ute to the cause of death? Probably 4 Dunknown re autopsy findings available or to completion of cause of th? Yes 2 No (Specify) or Rural Route Number. er as stated. I due to the cause(s) |
| IVISION Of VITAI Records, P.O | r Attanding Physician: The law requires that the ter death. The transport Attenthis certificate has been signed by the by the funeral director, page 2 should be detachen by the funeral director, page 2 should be detachen | Medical Certification: To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not examiner? 25. Was case referred to medical examiner? 1 Yes No Hospital: | resulting in the un Cooking Term 23a) (Type, P | other (specify) Identying cause give Si 5 28c. Injury Work: M 1 Y Identy factory, office coccurred at the time estigation, in my opi 29c. License DOC Print) Way | 26. Place of Death 4 Nursing Hom at 2? es 2 No 2 a, date and place, annion, death occurre | 24a. Was an autopsy perform 1 Yes 2 (Check only one see 5 Resider 8d. Describe how city or Town, and due to the caud at the time, dai | Month acco use contributes 2 No 3 24b. We prior dea 1 24b. We prior dea 1 31ce 6 Other (av injury occurred set and Number of State) use(s) and manne e and place, and d. Date signed (A | Day Year ute to the cause of death? Probably 4 Unknown re autopsy findings available or to completion of cause of th? If Yes 2 No (Specify) Or Rural Route Number. er as stated. |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** PATRICIA ANN MARTIN 2006 23 November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Harford Havre de Grace If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1/7/1938 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 212-38-0465 68 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28e-f ehow 10a. State 10b. County 1 TyrYes 2 ☐ No MDHarford Havre de Grace by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number DUST DE 4116 Webster Lapidum Road 21078 USA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2√ No If Yes, Give \(\text{Year or Dates:}\) 1 Never Married 2 Married ŏ Maryland 21215-0036 1 ☐ Yes 3 ☐ No Specify: Specify: White 3√2 Widowed 4 □ Divorced "naturei" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Mi Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be fund Mental P Searum L. Ellis Annie E. Sigler ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pamela Workman/Daughter 2201 Line Bridge Road, Whiteford, MD Health permit. Pages 1 and Depertment of Health Important: if item 27 any injury or other tr 900ca. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Highview Mem. Gardens 11/28/2006 Fallston, MD 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Acute Coronan resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (b) as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit Hyporcholo Jerolani Due to bas a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 2 ER/Outpatient 3 DOA ۵ 1 Yes this atricia rector: After this by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 atural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ă within 24 hours e To the Funerei [To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 23,2006 Harford Memoria Hospital, Hourede Grace MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wadtes Meum 32 egistrar's Signature 31. Date filed (Month, State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Nov 17, 2006 Year **Physician** 0315 Minnick /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany Cumberland Allegany County Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jun 28, Birthplace (State or Foreign
 Country) 6 Sex 5. Social Security Number **Funeral** 1√ M 2 F 85 170-12-3896 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show r then "neturel", or Items 23a or 28a-f shor the Medical Examinatment be notified at Bedford Bedford 1 ☐ Yes ⊋ ☐ No PA Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code USA 15522 7185 Valley Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Year or Dates: 3 XWidowed 4 □ Divorced .WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other then Railroad laborer 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 is marked oth ery lighty or other treumatic event size. 17. Father's Name (First, Middle, Last) Annie College Minnick unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21502 904 Kentucky Avenue Cumberland daughter Lisa Van 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 11/20/2006 Cumberland MD Sunset Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service License holax 108 Virginia Avenue; Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE CONCESTIVE DAY **Physician** HEXRT disease or condition resulting in death) /Medical **Examiner** TENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No for 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown cate has been signed by I page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 | Yes 2 INo 3 | Probably 4 | Unknown LNNG Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2□ No 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Hospitel or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident after death 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 1486 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Robustiano Barrera M.D. Mem. Hosp Med Bldg Cumberland MD 21502

| | | | For State Registrar | State of I | Marylar | | artmen rtificat | | | ınd M | | giene Reg. No.2 | 306 | 37951 |
|---------------------|--|----------------|---|---|-------------------------------|-----------------------------|---------------------------------------|--------------------------------------|---------------------------------------|------------------------|--|---------------------|--|---|
| 76 | € * | | Decedent's Name (First, Middle, | Last) | | | - | | | | 2. Date of Dea | ıth | Year | 3. Time of Death |
| | Physicia /Medic | | Susan | Virgini | | Mitts | | | | | Novembe | | | 4:10 p M |
| | Examin | er - | 4a. Facility Name (If not institution, 405 Center Stre | eet | | | F | ceder | | | | Fr | ederic | ck |
| 變 | Funeral Director | | 215-44-7649 | 3. Sex 7. 1 □ M 2√2 F | Age (In yrs. | iast birthday) Yrs. | Months | 1 Year Days | If Under 2 Hours | Min. | 8. Date of Birtl (Month, Day Aug. 20 | , ^{re} 194 | 9. Birth | place (State or Foreign ntg.) YLand |
| | and | | Usual Residence of Decedent 10a. State 10b. County | | 10c. Ci | ty, Town or Lo | cation | | | | | | | 10d. Inside City Limits |
| | Mary Ind | tor | Maryland Freder | ick | F | rederi | ck | | | | | | | 1 XYes 2 No |
| | with the | i Director | 10e. Street and Number 405 Center S | treet | | | 10f. Zip | Code 1701 | | | | 10g. Citizen U.S | of What Cou | ntry? |
| 036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent; if item 27 is marked other then "natural", or items 23a or 28a-f show applyingury or other traumatic event, the Madical Exert ther must be notified a once. | by Funeral | 11. Marital Status 1 ☐ Never Married 2 🌠 Marrie 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decede Armed Force d 1 □ Yes 24 If Yes, Give Year or Date | s? X No | | Was Decedif Yes, spe | cify Cuba | spanic Orig n, Mexican Specify: | gin? (Spe i, Puerto | city Yes or No- Rican, etc.) | | Race - Ameri Black, White, ecify: Wh | |
| 215-0 | hin 72 ho s. nn "natur Mudical | Completed | 15. Decedent'. (Specify only highest Elementary/Secondary (0-12) | Education grade completed) | or 5+) | 16a. Dece (Give life. | dent's Usu kind of wo DO NOT u | al Occupa rk done d se retired | ation lu <i>ring</i> most) | t of workii | ng | 16b. Kind o | f Business/Ir | ndustry |
| 212 | ad with | Com | 11 | | | A | ssemb | 1y L | | | | | factur | ing |
| Maryland 21215-0036 | utd be fil Mental H irked oth | To Be | 17. Father's Name (First, Middle, L John Arthur | | | | | | | | (First, Middle, | | | |
| /au | 2 sho | | 19a. Informant's Name/Relationsh | | | | - | | | | l Route Numbe | | | p Code) |
| | 1 and Health am 27 ther t | | Henry J. Mitts, | nuspand | 20b. I | Place of Dispo | sition (Na | me of | - 1 | | derick, | | on - City or T | own, State |
| JOIT. | Pages ent of nt; if it | | 1 N Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp | | | cemetery, crea unt Oliv | | | | 7. 22 , | 2006 | Fre | derick | , MD |
| Baltimore, | permit. F Departm Importer any injur | | 21. Signature of Funeral Service L | | MOO | 255 1 | Keen | ey a | nd Facilit | sfor | d PA Fu | meral | Home | 21701 |
| 1 | en see se | | 23a. Part1. Enter the disease, or o shock, or heart failure. List of | complications that cau | sed the dea | | | | | | | | City IID | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | | | in Meta | astes | es | | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or | as a consec | quence of): | | | | | | | | 00 1 |
| | | er | Sequentially list conditions, if any, leading to immediate | | mall (| cell ca | arcin | oma | | | | | | 90 days |
| V | d d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | | | |
| 8760, | ate be executed hysicien and the burial-transit | al Exa | resulting in death) Last | Due to (or | as a consec | quence of): | | | | | | | | |
| 687 | physicate to physical street. | edical | LI. | d | | | | | | | | | | |
| Box | that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | 23c. If yes, outco 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknow | n 2 ☐ Feta t at time of o | al death 3 |]Ectopic p] Other (s _i | | | | | 23d. | Date of deliv Month | very Day Year |
| ls, P.O. | es De de | by | Part II. Other significant condition Basal-cell sk | | h but not re | sulting in the u | nderlying | ause give | en in Part I. | | | obacco use o | | the cause of death? |
| ord | w requir been si should | eted | Dasar Cerr 3k | III Cancer | | | | | | | - | | | |
| Il Records, | The ate h page | Completed | | | | | | | | | 24a. Was autop perfo | | prior to co death? 1 🗀 Yes | opsy findings available ompletion of cause of |
| Vital | ucian: Th certificate rector, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | | | Oth | | - | (Check only o | | | |
| o | Attending Physician: r death. sctor: After this certificator, by the funeral director, | lon: To | 1 Pes 2 No 27. Manner of Death 1 Natural 5 Pending | 28a. Date of (Month, | | 28b. Time of Injury | | 28c. Injury Work | 4 🗀 190 | | me 5 🔀 Resid 28d. Describe t | | | rfy) |
| Division | Pir Dir | Certification: | 2 Accident investig 3 Suicide 6 Could n 4 Homicide determi | ot be 28e. Place of | Injury - At h , etc. (Spec | nome, farm, st | | | 163 2 | | 28f. Location (S City or Tox | | umber or Rur | al Route Number, |
| | • Hospitel | edical C | | Physician: To the be examiner: On the bas and manner | is of examin | | | | | | | | | |
| | To the within 2 To the comple | Me | 29b. Signature and title of certain | Ca | a1 | 1 | 29 | c. Licens | | | į. | | gned (Month | |
| | | | 1/1/ for | rier | 11/ | ソ | | D09. | | | | | | , 2006 |
| | P | | 30. Name and address of berson v J.R. Poirier, | M.D., 186 | | | Print) Son D | rive | , Fre | deri | ck, Mar | yland | 21702 | |
| | Sta Regist | | 31. Date filed (Month, Day, Year) NOV 2 9 | 2006 Reg | istrar's Sign | Tyre So | will | | | | | | | |

| | | For State Registrar | State of Marylan | | | of Healt of Dea | | | giene 1eg. No2 0 0 6 | 37952 |
|--|----------------|---|---|---|------------------------------|-----------------------------------|-------------------------|--|---|---|
| Physicia | an | 1. Decedent's Name (First, Middle, Las | | | | | | 2. Date of Dea Month | Day Year | 3. Time of Death 2:35 AM |
| /Medic | al - | HELEN LUC 4a. Facility Name (If not institution, give | ILLE NUSBAUM | | 4b. City, T | own, or Locati | ion of Death | NOVEMBER | 4, 2006 4c. County of Dea | |
| Examin | er | 802 COXSWAIN WAY | , | | | ANNAPOI | LIS | | ANNE ARU | NDEL |
| Funeral Director | | 5. Social Security Number 6. S 577-18-1667 | ex | last birthday) Yrs. | If Under 1 Months | Year If Un Days Hou | der 24 Hrs. Irs Min. | 8. Date of Birth (Month, Day SEPTEMBER | r, Year) C | thplace (State or Foreign buntry) [RGINIA |
| ס | | Usual Residence of Decedent | | . T | | | | | | 10d. Inside City Limits |
| arylar ehow | 5 | 10a. State 10b. County | | ty, Town or Lo | ANNAPOI | TC | | | | 1 ☐ Yes 2X No |
| the N 28a-f | Directo | MARYLAND ANNE AR 10e. Street and Number | UNDEL | | 10f. Zip | | | | 10g. Citizen of What C | ountry? |
| 3a or | | 802 COXSWAIN WAY | #206 | | | 21401 | | | U.S.A. | |
| ore, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after deeth with the Maryland to the family and Mantal Hygiene. Item 27 is marked other then "natural; or items 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at | by Funeral | 11. Marital Status 1 Never Married 2 Married | 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give | .S. 13. | Was Decede If Yes, speci | fy Cuban, Mex | kican, Puerto | pecify Yes or No- Rican, etc.) | Black, Whi | te, etc. |
| hours tural | ed b | 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Ed | Year or Dates: | | | Occupation | | | 16b. Kind of Business | HITE Andustry |
| 215- | Completed | (Specify only highest gra | de completed) College (1-4or 5+) | (Give | kind of work DO NOT use | k done during e retired) | most of wor | king | | |
| 21. | Соп | | 2 | 1 | SECRETAI | | I-4hI- 81a | - /Cinch Mindello | IRS | |
| Maryland 21215-0036 nd 2 should be filed within 72 hours alt lith and Mental Hygiene. 27 is marked other then "natural", or rtraumatic event, the Mudical Exam | To Be | 17. Father's Name (First, Middle, Last) THOMAS HARRIS | | | | 18. M | | ARGARET CO | Maiden Sumame) OMPTON | |
| aumai | | 19a. Informant's Name/Relationship (| | | • | | | | or, City or Town, State, | |
| e, N I and Health Im 27 Ther tr | 1 8 | WILLIAM NUSBAUM, JR | 20b. I | Place of Disp | osition (Nam | e of | UPPER | MARLBORO, | MARYLAND 207 20c. Location - City o | |
| ages into the first i | H | 1 ∑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific | Removal from State | cemetery, cre | matory or ot | her place) RIAL PAR | K 11/7 | /2006 | ELKRIDGE, M | |
| Baltimore, permil. Pages 1 ar Deperment of Hea Important: If item eny injury or othe once. | | 21. Signature of Funeral Service Licer | nsee | 2 | 2. Name and | d Address of FINALDI F | acility UNERAL | HOME, INC | | |
| _ 40204 | | 23a. Part1. Enter the disease, or com | plications that caused the dea | | | | | | VER SPRING, M | Approximate Interval Between |
| Physician | | shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | a. ACUTE | Lei | Kem | ia | | | | Onset and Death |
| /Medical Examiner | | 1 | Due to (or as a consec | quence of): | chi | Sund. | (0.00 | | | 2 years |
| D # | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury | Due to (dr as a consec | quence of): | J/1- | 7.7.5 | CIV SC | | | |
| 18760, cete be executed physicien and ithe burial-transit | Examiner | Cause (Diseese or injury that initiated events resulting in death) Last | c Due to (or as a consec | quence of): | | | | | | |
| 8760, sete be exchysicien at the burial | icai | (| d | | | | | | | |
| x 68 entifice ding pt | /Med | IF FEMALE: | 23c. If yes, outcome of pregn | ancv | | | | | 23d. Date of de | liven. |
| , P.O. Box 68 that the death certifice ed by the ettending pl detached for use as t | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown | 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown | ai death 3 | □Ectopic pre □ Other (spe | | | ==== | Month Month | Day Year |
| ecords, P.O law requires that the ss been signed by th 2 should be detach | ρ | Part II. Other significant conditions | contributing to death but not re | sulting in the | underlying ca | ause given in F | Part I. | 23e. Did to | obacco use contribute res 2 No 3 ☐ F | o the cause of death? |
| Records, the taw requires t the tes been signe age 2 should be | Completed | | | | | | | 24a. Was | an 24b. Were a | utopsy findings available |
| The The sage | mo: | | | | | | | | rmed? death? | completion of cause of s 2□ No |
| of Vital Physician: Tribis certificer | Bec | 25. Was case referred to medical examiner? | | | | | Place of Dea | ath (Check only o | ne | |
| of Vita Physician: this certific | မ | 1 ☐ Yes 2 ☐ No | 1 | ER/Outpatie | | | ☐ Nursing H | T | dence 6 Other (Sp | ecify) |
| Ing Afte | tion: | 27. Mannér of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio | 28a. Date of Injury (Month, Day Year) | 28b. Time Injury | M Z | 8c. Injury at Work? 1 ☐ Yes | 2 🗆 No | 280. Describe r | now injury occurred | |
| or Attender dea Director in by the | Certification: | 3 Suicide 6 Could not b 4 Homicide determined | De Geo Place of Injury . At I | | treet, factory | , office | | 28f. Location (S City or Tox | Street and Number or F vn, State) | Rural Route Number, |
| To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by | ledicai C | | hyeician: To the best of my kn miner: On the basis of examin and manner stated. | | | | | | | |
| ro the vithin ro the | Z | 29b. Signature and title of certifier | | | 1 | . License num | | 1 | 29d. Date signed (Mor | |
| | | Illenon V | ven MD | | |)5Z8 | 30 | | November (| 0,2006 |
| | | 30. Nam + Ind address of person who | ~ ~ | m 23a) (Type Best | Print) | wid # | 300, | Ango | Wvember o | 21401 |
| Sta Regist | | 31. Date filed (Month, Day, Year) | 2006 32 Registrar's Sign | de la la la la la la la la la la la la la | all | | , | | | |

| | | | 1 - For State Registrar | State of I | | nd / Dep | | t of H | lealth a | | | giene | 006 | 379 | 53 |
|---------------------|--|----------------------|---|--|-----------------------------------|--|---|--|----------------------|--------------------------|--|---------------------|---|---|-----------------|
| 3 | Physic /Medi | | Decedent's Name (First, Middle, I HELEN J. NICOLL | Last) | | | | | | | 2. Date of De Month NOVEMBE | ath | | 3. Time of D | |
| | Exami | | 4a. Facility Name (If not institution, g | | er) | | | | Location o | | | 4c. Co | ounty of Death | | |
| 64 | Funeral Director | | 5. Social Security Number 6. 155-07-6259 Usual Residence of Decedent | Sex 7. 1 ☐ M 2 🛣 F | Age (In yrs. 86 | last birthday Yrs. | Months | 1 Year Days | If Under 2 Hours | Min. | 8. Date of Bird (Month, Da MAY 16, | h y, Year) | 9. Birth | place (State or F Intry) NNSYLVANI | Foreign A |
| 336 | the Maryland 28a-f ahow | Director | 10a. State 10b. County MARYLAND MONTGON 10e. Street and Number | ŒRY | 10c. Cit | y, Town or L | ocation R SPRIN | | | | | 10- 00 | | 10d. Inside City 1 ☐ Yes 2 | |
| | is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural; or items 23a or 28a-f ahow other traumetic event, the Madical Expendent with bu furtilled at | by Funeral | 15211 ELKRIDGE WAY 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decede Armed Force | s? ∑No | | | 2 lent of Hi offy Cuba | | gin? (Spec , Puerto F | | UNITED 14. | Race - Amer Black, White | OF AMERICA | A |
| Maryland 21215-0036 | d within 72 ho giene. or then "natur the Medical | Completed | 15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12 | Education trade completed) College (1-4c | or 5+) | 16a. Dece (Give life. | dent's Usua kind of wor DO NOT us HOMEMA | rk done a se retired, | ition luring most | of workin | g | | of Business/li | ndustry | |
| ryland | should be filed and Mental Hygis marked other umatic event, I | To Be C | 17. Father's Name (First, Middle, Las MATTHEW SPRYN 19a. Informant's Name/Relationship | | | 405 14 | | | | SC | (First, Middle, | Maiden Su EROSKY | mame) | | |
| ore, Ma | jes 1 and 2 s of Health an if item 27 is or other trau | | ALISON MARTIN - DAU 20a. Method of Disposition 1 Burial 2 Cremation 3 | GHTER | 20b. P | | JALMIA | ROAD | ; MOUN | T AIRY | Route Numbe 7 MARYLAI ate | ND 2177 | | | |
| Baltimore, | permit. Pages Department of I Important: If its any injury or o | | 4 Donation 5 Other (Spec | cify) | | LINCOLN 2 | 2. Name an | d Addres | s of Facility | 11/15/ HINES | /06 5 - RINAI SILVER S | DI FUN | ITWOOD, N IERAL HON MARYLAN | Æ. INC. | - |
| | Physician /Medical Examiner | er | 23a. Part Early the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | a. RIGHT P | ARIETAI s a consequ FIBRILI | LOBE (Jence of): ATION | | | | | respiratory an | rest, | | Approximate Interval Betwee Onset and Dea | |
| 68760, | The law requires that the death certificate be executed to has been signed by the attending physician and rage 2 should be detached for use as the burial-transit | ical Examin | cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last | c. <u>DIABETE</u> | S MELLI | TUS Dence of): | SE | | | | | | | | |
| O. Box | the death certific y the attending p ached for use as t | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown | 23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown | 2 Fetal | death 3 | Ectopic pre | | | | | 23d. | . Date of deliv- Month | ery Day Yea | ır |
| ecords, P | w requires that the de been signed by the a should be detached f | þ | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | he cause of deat | | | |
| r | | e Completed | 25. Was case referred to medical | T | | | | | | | 24a. Was a autops perform | v | 4b. Were auto prior to co death? 1 \(\sum \text{Yes}\) | psy findings ava mpletion of caus 2译No | ilable se of |
| VISION OT VII | To the Hospital or Attending Physicien: within 24 hours stater death. To the Funaral Director: After this certifical completely filled in by the funeral director; p | Certification: To Be | examiner? 1 Yes 2 No 27. Magner of Death 1 Natural 5 Pending 2 Accident investigation | | | ER/Outpatier 28b. Time of Injury | | 28c. Injury at Work? 28d. Describe how injur | | | эпсе 6 | | y) | | |
| S S | spital or Att | | 3 Suicide 6 Could not determined | building, e | etc. (Specify | ·) | | | | 4.0 | City or Towi | n, State) | | al Route Number | ; |
| | To the Hospital or At within 24 hours after of To the Funaral Direct completely filled in by | Medical | (Check only one) 2 Medical Example of certifier | hysician: To the bes miner: On the basis and manner s | or examinati | viedge, deati ion and/or in | vestigation, | t the time in my opi License | nion, death | place, an occurred | l at the time, d | ate and pla | d manner as si ce, and due to gned (Month, | the cause(s) | |
| G | 3 | | 30. Name and address of person who | completed cause of | death (Item | 23a) (Type, | Print) | D006 | 2520 | | | | MBER 6, | | |
| 140 | Sta | te_ | MARIA KAYAGA D'ARI 31. Date filed (Month, Day, Year) | BELA 150 | 00 FORE | ST GLEN | ROAD, | SILVE | R SPRI | NG, M | D 20910 | | | | |
| | Registra | | NOV 08 20 | | | | 2 | | | | | | | | |

JAMES

Due to (or as a consequence of)

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 4 Inpatient

28a. Date of Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician /Medical Examiner

Examine

Physician/Medical

Completed

Be

Medical

IF FEM 23b. W

attending physician

Division or Vital Records, P.O. Box 68760

| IALE: as decedent pregnant the past 12 months? Yes 2 140 | 23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown |
|--|---|
| Unknown | 9D OIIKIIOWII |

5 Pending investigation

6 ☐ Could not be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manne of Death

1 Natural

2 Accident

3 Suicide 4 ☐ Homicide

| ome pf pregnancy th 2□Fetal death int at time of death | 3 □Ectopic pregnancy 5 □ Other (specify) |
|--|---|
| A/D | |

2 ER/Outpatient 3 DOA

28b. Time of

| B⊟Ectopic pregnancy □ Other (specify) | |
|---------------------------------------|--|
| | |

| 23d. Date of Month | delivery Day |
|-----------------------|-----------------|
| | |

2006

Birthplace (State or Foreign Country)

10d. Inside City Limits

Onset and Death

Year

1 Yes 2 No

Maryland

White

| 23d. | Date of | delivery | |
|------|---------|----------|--|
| | Month | Day | |
| | | | |
| | | | |

| 23e. Did tobac | co use con | tribute to the cau | se of death? |
|----------------|------------|--------------------|--------------|
| 1 ☐ Yes | 2 No | 3 ☐ Probably | 4 Unkno |

24a

| 1 ∐ Yes | 2 LINO | 3 ∐ Prol | bably | 4 ∐Ur | ıknov |
|---------------------------|--------|--|---------|-----------|--------|
| Was an autopsy performed? | | Were auto prior to co death? 1 \(\subseteq Yes | mpletic | on of cau | /ailab |

| | | 00 | |
|----|-------|-------------------|---|
| at | h (Cl | neck only one) | |
| Ho | me | 5 ☐ Residence | 6 ☐Other (Specify) |
| | 28d. | Describe how inju | Iry occurred |
| т | 206 | 1/ (01 1 - | and Alicenters are December December Alicenters |

| (WOIMI, Day Year) | M | 1 ☐ Yes | 2 □ No | |
|---|------------------------------|---------------|--------|---|
| 28e. Place of injury - At ho building, etc. (Specify | ome, farm, street, fac y) | ctory, office | | 28f. Location (Street and Number or Rural Route City or Town, State) |
| | | | | |

Other: 4 Nursing

| 9a. Certifier (Check only one) | 1 ★ CertifyIng Physician: To the best of my knowled 2 ★ Medical Examiner: On the basis of examination and manner stated. | edge, death occurr n and/or investigat | ed at the time, date and place, and due to to ion, in my opinion, death occurred at the time | ne cause(s) and manner as stated. ne, date and place, and due to the cause(s) |
|--------------------------------------|--|---|---|---|
| b. Signature and | ititle of certifier ABrull MO Personce/1 | Physician | 29c. License number 000 4359 | 29d. Date signed (<i>Month</i> , Day, Year) NOV 15 2006 |

| | . 1 | our | W NO | LE IV | 101 | SUREE | 114 | or Cia |
|----|------|-------------|-----------|---------------|----------|-------------|---------|------------|
| 0. | Name | and address | of person | who completed | cause of | death (Item | 23a) (T | ype, Print |

| 30. Name and address of person who Robert Brull | o complete | od cause of death (Item 23a) (Type of CotoMac ST. | e, Print) | erstown, | 14 | 2174 | - |
|---|------------|---|-----------|----------|----|------|---|
| 31. Date filed (Month, Day, Year) | | 32. Registrar's Signature | ~ | , | | | |

State Registrar

To the within 2

JH-2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydienes O. O.

| | | | 1 - For State Registrar | | State o | of Maryla | nd / De _l | partment of e <i>rtificate of</i> | Health a <i>Death</i> | and Mental H | ygier Reg. 1 | | 37956 | | | |
|--|---|---------------------|---|--|--|---|----------------------|---|--------------------------|---|---------------------------------|---|---|--|--|--|
| | Physici | | | ne (First, Middle, La Berta | ist) | | Ont1 | | | 2. Date of I Month Novemb | | Day Year | 3. Time of Death | | | |
| | /Medio Examir | | | If not institution, giv | re street and nu | | OIICI | 4b. City, Town, | or Location o | | | 14 2004 tc. County of Dear | | | | |
| # | Funeral | ler | | on County | y Hospit | | s. last birthda | Hages | stown | 24 Hrs. 0. Date of 6 | Diad b | Washingt | CON | | | |
| | Director | | 149-26-4 | 516 | 1□M 21xF | 91 | Yrs. | Months Days | Hours | Min. (Month, I Sept. 6 | Day, Yea 191 | .5 Czec | h Republic | | | |
| 7 | 2 | | Usual Residence o | | | | | | | ,50,50. | , | | | | | |
| 2 | hov and | - | 10a. State | 10b. County | | 10c. C | City, Town or | Location | | | | | 10d. Inside City Limits | | | |
| N o | 89-1-a | cto | MD | Washing | gton | | Hagers | town | | | 1 ∑ Yes 2 | | | | | |
| dit. | 0.0 | H | 10e. Street and Nu | | | | | 10f. Zip Code | - | | | Citizen of What Co | • | | | |
| book with the Manland | 8 2 3 8 | a | | 1 Highway | | | | 2174 | | | | Czech Republic | | | | |
| | | by Funeral Director | 11. Marital Status 1 □ Never Marr 3 🏿 Widowed | ried 2□ Married 4 □ Divorced | 12. Was Dece Armed Fo 1 Tyes If Yes, Gin Year or D | 2 🔯 No ve | U.S. 13 | i. Was Decedent of If Yes, specify Cui | | gin? (Specify Yes or N , Puerto Rican, etc.) | No- | 14. Race - Ame Black, Whit | e, etc. | | | |
| | natur lica | ted | /Saar | 15. Decedent's E | ducation (1444) | | 16a. Dec | edent's Usual Occu | pation | | 16b. | Kind of Business/ | Industry | | | |
| Z 1 Z 1 Z | tal Hygiene. d other than "natural", or its event, the Medical Examina | Completed | Elementary/Seco | ondary (0-12) | | College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired) Head Cook | | | | | Nu | ursing Ho | ome. | | | |
| ב פ | oth oth | Be | 17. Father's Name | (First, Middle, Last |) | | | | 18. Mother | r's Name (First, Midd | | | | | | |
| | Mental Merked o | To E | Unknow | n | | | | | Ruzer | na Michova | | | | | | |
| lary la | and I | | 19a. Informant's N | ame/Relationship (| Type, Print) | | 19b. Ma | iling Address (Stree | and Number | r or Rural Route Num | ber, City | or Town, State, 2 | Zip Code) | | | |
| , , | n 27 | | Terri H | . Anderso | on / Fri | end/P.F | R. 1023 | Kinzel I | r. Wir | nchester, | VA 2 | 22601 | | | | |
| - ע | of Hear | | 20a. Method of Dis | position | Pamoval from | | Place of Dis | position (Name of ematory or other pla | ice) | Date | 20c. | Location - City or | Town, State | | | |
| | ment ment ent: I | | 4 Donation | 5 Other (Special | y) | | ithsburg | Crematoriu | m 1 | 1/16/2006 | Smi | thsburg, | MD | | | |
| | perimit. Fages I and a Department of Health a Importent: If Item 27 is eny injury or other tre | | 21. Signature of Fu | uneral Service Lice | nsee / | | | 22. Name and Addr | ess of Facility | Gerald N | . Mi | nnich Fu | neral Home | | | |
| L | 10 E E G | | 103 | m- 7 | | | 3 | 05 N. Pot | omac S | St. Hagers | town | , MD 217 | 40 | | | |
| | | | 23a. Part1. Enter t shock, or hea | he disease, or com ort failure. List only | plications that o one cause on e | aused the dea | ath. Do not e | nter the mode of dy | ng, such as o | cardiac or respiratory | arrest, | 110000000000000000000000000000000000000 | Approximate Interval Between | | | |
| | hysician | 419 | Immediate Cause disease or condition | (Final | . 2 | Se | DSB | | | | | | Onset and Death 24-hous | | | |
| | /Medical xaminer | | resulting in death) | • | Due to | or as a conse | quence of): | | | | | | | | | |
| _ | .xaiiiiiei | | Sequentially list co | nditions, | b | 16 | und | eu | | | | | 24 hores | | | |
| þ | s lis | line | Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events | nmediate erlying | Due to (| (or as a conse | quence of): | | | | | 1 | | | | |
| recut | and I-tran | Examiner | that initiated events resulting in death) | Last | C | or as a conse | quence of): | | | | | | | | | |
| | physician and sthe burial-transit | aiE | | | | 01 45 4 551155 | quonos on. | | | | | | | | | |
| uticate be executed | phys s the | edicai | | • | d | | | | | | | | | | | |
| Hospitel or Attending Physician: The law requires that the death certi | by the attending p | Physician/Me | | | | | | | | | | 23d. Date of deli Month | very Day Year | | | |
| that | ed by detac | | Part II. Other signif | ficant conditions | ontributing to de | ath but not re | sulting in the | underlying cause or | en in Part I | 23a Did | tobacco | use contribute to | the cause of death? | | | |
| requires | been signed I | eted by | | | | | | | | | | | bbably 4 DUnknown | | | |
| The law | nis certificate has b I director, page 2 s | Completed | | | | | | | | | san opsy formed? 2√⊡-N | prior to death? | topsy findings available completion of cause of | | | |
| ician | ector | Be | 25. Was case refer examiner? | | Manufal (A) | | | | | of Death Check only | onel | | | | | |
| 5 £ | this aldir | ٩ | 1 Tes 2 2 | | | · | ER/Outpatie | ALL OUX | | sing Home 5 Res | | | eify) | | | |
| in Sign | h. After funer | 0 U | 1 Natural | 5 Pending | | h, Day Year) | 28b. Time Injury | Wo | | 28d. Describe | how inji | ury occurred | | | | |
| tten C | death stor: / the | icat | 2 ☐ Accident 3 ☐ Suicide | investigation 6 Could not b | | of Injury - At h | omo ferm e | M 1 [| Yes 2 □ N | | /G | -141 | | | | |
| 20 | after Direction of the control of th | Certification | 4 Homicide | determined | buildir | ng, etc. (Speci | ify) | пен, гастогу, опісе | | City or To | (Street a wn, Stai | and Number or Ru. te) | ral Houle Number, | | | |
| spite | ours filled | | 29a. Certifier | 1/X Certifying Ph | vsician: To the | best of my kn | owledge dea | th occurred at the ti | me date and | place, and due to the | 20000/ | 0) and manner | | | | |
| e Ho | within 24 hours after death. To the Funeral Director: A completely filled in by the fr. | Medical | (Check only one) | 2 Medical Exam | niner: On the ba and mann | asis of examina | ation and/or i | nvestigation, in my | ppinion, death | occurred at the time | , date ar | nd place, and due | to the cause(s) | | | |
| To the | withir To th somp | X. | 29b. Signature and | title of certifier | | | | 29c. Licens | e number | | 29d. D | ate signed (Month | , Day, Year) | | | |
| , | | | > de | mou | gsuc | of | | 1 | 2836 | 55 | 11 | 1-14-06 | | | | |
| | , | } | 30. Name and addr | ess of person who | completed cause | of death (Ite | m 23a) (Type | | | | | | | | | |
| 5H | -1 | | MANZ | - AR. D | SHAM | \ / | nell S | | agers | town 1 | 70 | 21740 | a a | | | |
| | Sta | | 31. Date filed (Mon | | | egistrar's Sign | ature | | 0 | | | | | | | |
| | Registra | ar | | VOV 16 20 | JUD / | offices of | 8. D. | will | | | | | | | | |

06-08765 Dale L. O'Hara

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

| | | 1- For State Registrar | | | Reg. No. 2005 37 | | | | | | | | |
|--|--|--|----------------------------|---|-----------------------------------|---|--------------------------------------|---------------------------|---------------------------|---|----------------------------|---|--|
| Physici Medical Exami | | Decedent's Name (First, Midd | DAL | | Date of Dear Month November | Day Yea | | Time of Death 1700 hrs | | | | | |
| | | 4a. Facility Name (if not institution Northwest Hospital | on, give street and nu | ımber) | 41 | c. City, Town, Randalisto | | Death | | 4c. County of Baltimore | | :у | |
| Funeral Director | | 5 Social Security Number 213-84-7915 | 6. Sex | 7. Age (In yrs. last b | oirthday) Yrs. | If Under 1 You Months Da | ear If Under ays Hours | 24Hrs. Min. | | h(MM/DD/YYYY) 6/1958 | | olace (State or try) MARYLAND | |
| Aaryland 28a-f show any 1 at once. | ٥r | Usual Residence of Decedent 10a State 10b. County MD CARR | OLL | 10c. City, Tov | vn or Locatio | | | | | | | 0d. Inside City Limits XYes 2 No | |
| th the Maryl 23a or 28a-I notified at 9 | Director | 10e. Street and Number 101 CHARLES | ST., AP | Г. L | | 10f. Zip Code 2115 | | - | 10 | Og Citizen of Wh | at Country | 1? | |
| death wi | by Funeral | - | arried Armed Fo | 2 X No | If Ye | Decedent of H s, specify Cub Yes 2X N | an, Mexican, F lo <i>specify:</i> | Puerto Ri | can, etc.) | r No- 14. Race - American Indian, Blan White, etc. Specify: WHITE | | | |
| imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. | ompleted | 15. Decedent's Education (Spe Elementary/Secondary (0-12) 1 2 | College (1-4 or 5+) | | | s Usual Occup st of working li ERVIS(| fe. DO NOT u | | | 16b. Kind of Bus | | yntek | |
| 21215-0036 ould be filed within 7 Mental Hygiene. marked other than cevent, the Medica | Be C | _ | ATRICK | O'HARA, | | | Č | JOAN | INE | laiden Surname) ARNOLI | D | | |
| MD 21 and 2 should beath and mer em 27 is mar raumatic eve | 2 | 19a. Informant's Name/Relations VICKI LYN O 20a. Method of Disposition | | WIFE 1 | 101 C | HARLES | S ST., | , AP | T. L, | WESTMI | NSTE | | |
| Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumati | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Loc 20c. L | | | | | | | | | | SYKESVILLE, MD UNERAL HOME | | |
| Physician | | 23a Part I. Enter the disease, or failure. List only one cause | complications that ca | aused the death. Do | 254 | E. M | AIN S | Т | WEST | ITNSTER | - MT | | |
| xaminer | | Immediate Cause (Final disease or condition resulting in death) | a. Narcoti Due to (or as a | c (methadone consequence of): |) into | cication | | | | | | Death | |
| | aminer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a | ed berry and consequence of): ensive ather consequence of): | | otic car | liovascu | lar d | isease | | | | |
| 58760, σ rrificate be executed ling physician and as the burial - transit | lical Ex | X UNPENDED | d. X AMENDED | #23a-c,27, _I #23a,27,28a- | enÆ, g | 863 1/26 | 0/0/ TT | | | | | | |
| P.O. Box 68760, that the death certificate by med by the attending physicate by the attending physicate by the attended for use as the bu | | IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unk | e 23c. If yes, o | outcome of pregnance irth ant at time of death | ₂ Feta | | Ectopic p | | <i>y</i> | 23d. Date of o | delivery Day | Year | |
| % an o | ŝ | Part II. Other significant conditi | ons contributing to | death but not result | ing in the un | derlying cause | given in Part | l. | 1 Yes | | Probabl | y 4 🗹 Unknown | |
| Division of Vital Records, lal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be | Completed | 25. Was case referred to medical | | | | | (D - 1) (O | | 24a. Was a autops perform | y pr med? de | | sy findings available pletion of cause of | |
| of Vital P Physician: er this certifi eral director, | To Be | examiner? 1 Yes 2 No 27. Manner of Death | Hospital: 1 Ir | npatient 2 ER/ | Outpatient | 3 DOA | Other at Work? | Nursing H | lome 5 i | Residence 6 | Other: | | |
| ision of 'Attending Pher death. | Certification: | 1 Natural 5 Pend 2 Accident Inves | tigation 28e Place | Day, Year) 1/17/2006 fin of Injury - At home, | d 4:19 | pm 1 _X | Yes 2 N | lo - t | ınknown- | | | Route Number, City | |
| Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: | | 4 Homicide | mined (Specify) | Northwest | Hosptal | | | ı R | or Town, St and all st | ate 54 ()1 ()1 own , MD | d Cou | rt Road | |
| To the l within 2 To the I complete | 29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Da) | | | | | | | | | | | | |
| | | 30. Name and address of person | who completed caus | of beath (Item 23a) | cun? | 0.0 | .M.E. | | | November 1 | | | |
| ♦ St | ate | Theodore M. King, Jr., 31. Date filed (Month, Day, Year) | MD. Assista | Medical Exar | miner 1 | 11 Penn S | treet, Balti | more, I | MD 21201 | - | | | |
| Regist | | NOV 2 | | William D. | Jogod | ALL! | | | | | | | |

| | | | 1 - State Registrar/Amend#26.PerPhy | State of Maryla | and / Depa | | of Health an | | giene Reg. No 200 | 5 37958 | | | |
|---------------------|--|-----------------------|--|---|---|--|--|---|--|--|--|--|--|
| | Physici /Medic | | John Giovanni | Paliotta | | | | 2. Date of De. Month Novembe | ath | 3. Time of Death | | | |
| | Examir Funeral | ner | 4a. Facility Name (If not institution, give s 201 Secretariat 5. Social Security Number 6. Sex | Apt. L | rs. last birthday) Yrs. | Hav | | ace | 4c. County of De Harfo th v. Year) 9. B | | | | |
| | Director | | 036-22-2126 Usual Residence of Decedent 10a. State 10b. County | , 1932 N | Mass. | | | | | | | | |
| | the Mary | rector | MD Harfo | ord | Havre de | e Grace | | | 10g. Citizen of What | 1 X Yes 2 ☐ No Citizen of What Country? | | | |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If them 27 is marked other then "naturel", or items 23a or 28a-f ehow eny injury or other traumatic event, the Madical Examinar must be notified at once. | by Funeral Director | 201 Secretariat 11. Marital Status 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced | Apt. L 12. Was Decedent Ever in Armed Forces? 1 DYes 2 □ No If Yes, Give Year or Dates: 195 | | Was Decedent If Yes, specify | | ? (Specify Yes or No- uerto Rican, etc.) | USA 14. Race - An Black, Wh | A nerican Indian, | | | |
| Maryland 21215-0036 | d within 72 hou giene. ir then "nature the Medical E | Completed I | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) | cation | 16a. Dece (Give life. | dent's Usual O kind of work o DO NOT use n | lone during most of etired) | 1 | 16b. Kind of Busines | s/Industry | | | |
| ryland | should be file nd Mental Hyg marked othe imatic event, | To Be C | 17. Father's Name (First, Middle, Last) Tomaso A. Paliott 19a. Informant's Name/Relationship (Ty) | Name (First, Middle, Magiacomo | Maiden Sumame) | | | | | | | | |
| ore, Ma | ies 1 and 2 and 2 of Health ar if item 27 ie or other trau | | Ornella Paliotta / 20a. Method of Disposition 1 X Burial 2 Cremation 3 CR | spouse | | Worrel | 1 Ct. (| Crofton, M | | 4 | | | |
| Baltimore, | permit. Pag Department Important: eny injury o | | 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License | Ar. | 22 | . Name and A | emetery ddress of Facility Crain Hwy | Beall Fun | | 715 | | | |
| I | Physician /Medical Examiner | Examiner | | Due to (or as a consi | ath. Do not enter O 75. equence of): O(A): oquence of): | er the mode of NHY 1 | dying, such as car | diac or respiratory an | | Approximate Interval Between Onset and Death SECUMPS | | | |
| . Box 68760, | raw requires mat the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit | Physician/Medical Exa | IE EEMALE: | 3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of | nancy tal death 3 | Ectopic pregn | ancy | | 23d. Date of do | | | | |
| ds, P.O | signed by the a | کر | 23e. Did tobacco use contribute to the | | | | | | | | | | |
| Ĭ, | ete h | Completed | PLABETES MELL, HYPENTENSION | 703 | | | | 24a. Was a autops perior | an 24b. Were a prior to med? death? | autopsy findings available | | | |
| 5 | his c | ation: To Be | 25. Was case referred to medical examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | ospital: 1 ☐ Inpatient — 2≴ 28a. Date of Injury (Month, Day Year) | | 28c. | Out - | | ne. ence 6 □Other (Sp ow injury occurred | ecify) | | | |
| = : | ra after death rai Director: led in by the | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At building, etc. (Spec | city) | | | City or Town | | | | | |
| 100 | within 24 hours in To the Funeral completely filled | Medical | 29a. Certifier (Check only one) 1 Certifying Physical Examin 2 Medical Examin | ician: To the best of my kr er: On the basis of examinand manner stated. | nowledge death nation and/or inv | estigation, in n | o time, date and pl ny opinion, death o | ccurred at the time, d | late and place, and du | e to the cause(s) | | | |
| ۶ م | 17 | | 30. Name and address of person who con | Deleted cause of death (the | am 23a) (Tuna 1 | 0 | 33080 | | 11/5/06 | ,,,,,, | | | |
| K | Star Registra | _ | A | Avm Mp 32. Registrar's Sign | 2/ R/U | MASINE | PKuys | WIN A B | a angh | 2/2/7 | | | |

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital within 24 hours at To the Funeral C State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month)

29c. License number

056965

ML

29d. Date signed (Month, Day, Year)

and manner stated

Ragistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

| | | | For State Registrar | State of | Maryland / Dep <i>Ce</i> | artment of He rtificate of D | | | ene . No 2006 | 37960 |
|-------------|--|----------------|---|---|------------------------------|--|--------------------------------|---------------------------------|--------------------------------------|---|
| | Dhysisis | | 1. Decedent's Name (First, Middle | , Last) | | | 2 | 2. Date of Death Month | Day Year | 3. Time of Death |
| | Physicia /Medic | al | Scott Franklin | | | | | ovember | 9 2006 | 0300 MM |
| , | Examin | er | 4a. Facility Name (If not institution | | ber) | 4b. City, Town, or L | | : | 4c. County of Deat | |
| | | | 10920 Holly Te 5. Social Security Number | | . Age (In yrs. last birthday | | rstown If Under 24 Hrs. 8 | . Date of Birth | Washing | DON pplace (State or Foreign |
| | Funeral Director | | 217-18-7304 | 1 X M 2□ F | 83 Yrs. | Months Days | Hours Min. | (Month, Day, Y May 29 | 'ear) Co | aryland |
| | | - | Usual Residence of Decedent | | | | | may 25 | 1725 | |
| | how | | 10a. State 10b. County | | 10c. City, Town or L | ocation | | | | 10d. Inside City Limits 1 ☐ Yes 2X No |
| | e Ma Ba-f ● | Director | Maryland Wash | ington | Ная | erstown | | | | |
| | में 0 28 | Oire | 10e. Street and Number | | | 10f. Zip Code | | 10g | . Citizen of What Co | untry? |
| | ath w | | 10920 Holly Te | | | 2174 | | 4 - V N- | USA 14. Race - Ame | ican Indian |
| | er de | Funeral | 11. Marital Status 1 □ Never Married 2 Married | Armed Ford | es? | Was Decedent of Hisp If Yes, specify Cuban, | Mexican, Puerto Ri | ican, etc.) | Black, White | |
| 36 | irs aft | by F | 3 Widowed 4 Divorced | ied 1X Yes 2 If Yes, Give Year or Dat | es: WW 11 | 1 ☐ Yes 2X No | Specify: | | Specify: W | hite |
| 21215-0036 | within 72 hours after death with the Maryland ene. than "neturel", or iteme 23a or 28a-f ehow he Medical Ezamirar must be invittled at | ted | 15. Decedent | | 6b. Kind of Business/ | Industry | | | | |
| 215 | hin 7 | ple | (Specify only highes Elementary/Secondary (0-12) | College (1- | life. | kind of work done du DO NOT use retired) | rang most or working | ' | | |
| 7 | filed wit Hygiene other the | Completed | 9 | 0 | Sı | pervisor | | | Railroad | |
| p | be file tal Hy d oth | Be | 17. Father's Name (First, Middle, | Last) | | 1 | 8. Mother's Name (| | | |
| Maryland | s 1 and 2 should be filed within 72 hours after death with the Marylan if Heath and Mental Hygiene. Item 27 is marked other than "neture!; or Iteme 23a or 28a-f ehow other treumatic event, The Medical Examical International Countries and Countries of the Countr | T ₀ | Scott Franklin | | | ing Address (Street an | Lillian | | | in Code) |
| a Z | 12 sh h and 7 is m treum | | 19a. Informant's Name/Relations | | | | | | | |
| | 1 end Health em 27 other tr | | Doris Hebb Pit 20a. Method of Disposition | tenger - w | 20b. Place of Disp | O Holly Te | Da | | it, Md . ZI. | |
| Baltimore, | | | 1 ABurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S) | | tate | matory or other place) on Cemetery | | /06 H | ageretown | , Maryland |
| 틀 | 글로벌끝 . | | 21. Signature of Funeral Service | | | 2. Name and Address | | | uneral Ho | |
| ä | Depa Impo any i | | SCATT | Millian | me Se | 15 E. Wils | | | | yland 21740 |
| | | | 23a. Part1. Enter the disease, or shock, or heart failure. List | complications that ca | used the death. Do not er | iter the mode of dying, | such as cardiac or | respiratory arres | t, | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | Only one cause on the | hrouic of | betre tri | ie lung | . Air | 92.50 | Onset and Death |
| 1 | /Medical | | resulting in death) | Due to (c | r as a consequence of): | - I acqto | مر ره | gaire | | 75-00 |
| | Examiner | | Sequentially list conditions, | b | | | | | | |
| | pe iis | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (o | r as a consequence of): | | | | | |
| _ | and and II-tran | хап | that initiated events resulting in death) Last | c. Due to (c | r as a consequence of): | | | | | |
| 8760, | ate be executed thysicien and the burial-transit | cal E | | | | | | | | |
| 687 | | | | 0. | | | | | | |
| Вох | leath certifi attending I for use as | D/M | IF FEMALE: 23b. Was decedent pregnant | | ome of pregnancy | | | | 23d. Date of del | |
| _ | death e atte | Icla | in the past 12 months? 1 ☐ Yes 2 ☐ No | | nt at time of death 5 | □Ectopic pregnancy □ Other (specify) | | | Month | Day Year |
| 0 | that the death led by the atter detached for t | Physician/Med | 9 Unknown | | | | | | | |
| | res tha signed be det | | Part II. Dther significant condition | ons contributing to dea | ath but not resulting in the | underlying cause given | in Part I. | | cco use contribute to 2 □ No 3 Pr | |
| or d | w require been sig | ted | HIGHTOTHE | (S) | | | | 1 105 | 2□No 3MPr | |
| Records, | e law i hes b | Completed by | HVIGI FOSTEL | 14/204 | | | | 24a. Was an autopsy performe | prior to d | topsy findings available completion of cause of |
| <u> </u> | Page T | S | | | | | | 1 ☐ Yes 2 | | 2 No |
| Vital | Attending Physician: The ridadin. coath. cotor: After this certificate his yithe funeral director, page | Be | 25. Was case referred to medical examiner? | Hospital: | | Other | 26. Place of Death (| | | |
| | 두 두 등 | . To | 1 Yes No | 1 □ In | patient 2 ER/Outpatie | IN 30 DOA | 4 Nursing Home | e 5 Residen 3d. Describe how | ce 6 Other (Specification) | cify) |
| Division of | ding h. After fune | ton | 1 Natural 5 Pendin 2 Accident Investig | g (Month | , Day Year) Injury | Work? | es 2 🗆 No | | | |
| /isi | Atten deal octor: y the | fica | 3 ☐ Suicide 6 ☐ Could | not be 28e. Place of | of Injury - At home, farm, s | treet, factory, office | 28 | | et and Number or Ru | ıral Route Number, |
| á | s after | Certification: | 4 Homicide | buildin | g, etc. <i>(Specify)</i> | | | City or Town, | State) | |
| | Hospital 24 hours a Funeral I tely filled | | | | pest of my knowledge, dea | | | | | |
| | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer | ledical | one) | and mann | | | | | | |
| | To the I | Σ | 29b. Signature and title of certific | 1111 | | 29c. License | | 290 | d. Date signed (Monta | |
| ζ | 40 | | 1/1/0 | 10 | | DC | 6 806 | | veven | er 10,2004 |
| (| 8x1 | | 30 Name accordings of person | who completed cause | of death (Item 23a) (Type | Print) | | Hage | Varent | er 10,2006 WD 21742 |
| | | | 31. Date filed (Month, Day, Year) | 27 7 7 6 | · I · ENMY | 100ma | newe | 11476 | y run | W 61/16 |
| | Sta | 10 | 31. Date filed (Month, Day, Tear) | 32. ME | gistrar's Signature | | | | | |

| | | | For State Registrar | State of Marylar | | artment of H rtificate of L | | | ene 006 | 37961 | | |
|---------------------|---|----------------|---|--|------------------|---|---|--|--|-------------------------------------|--|--|
| | | | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of Death Month | Day Year | 3. Time of Death | | |
| | Physici /Medic | | Dorothy Selden Pa | ickard | | | | r 4, 2006 | 12:45 ^{P M} | | | |
| | Examin | | 4a. Facility Name (If not institution, give stre | | | 4b. City, Town, or | Location of Death | | 4c. County of Dea | | | |
| | | | Heron Point | | 30 | Chesterto | | | Kent | | | |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. | | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | Date of Birth (Month, Day, | 9. Birthplace (State or Foreign Country) | | | |
| | Director | | 336-20-0585 | ² ☐ F 85 | Yrs. | | | 0ct. 14 | , 1921 W: | sconsin | | |
| | and * | } | Usual Residence of Decedent 10a, State 10b, County | 10c. Cit | ty, Town or Lo | cation | | | | 10d. Inside City Limits | | |
| | /anyt | 5 | Maryland Ken | nt | Chest | ertown | | | | 1 □ Yes Ž No | | |
| | 28a- | Director | 10e. Street and Number | | | 10f. Zip Code | - | 10 | g. Citizen of What C | ountry? | | |
| | with a or | ₫ | 501 E. Campus Ave | USA | USA | | | | | | | |
| | hours after deeth with the Maryland tural, or Items 23a or 28a-1 show at Examinal must be notified at | Funeral | | Was Decedent Ever in U | .S. 13. | Was Decedent of H | ispanic Origin? (Spe in, Mexican, Puerto F | cify Yes or No- | 14. Race - Am | | | |
| (0 | riter | F | 1 ☐ Never Married 2 ☐ Married | Armed Forces? 1 ☐ Yes 2 ☐ No | 1 | | | tican, etc.) | Black, Whi | | | |
| 03 | ali, o | b | 3 Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | 1 ☐ Yes 2Ã No | Specify: | | SpecifWhit | :e | | |
| 2-0 | i within 72 hours jiene. r than "naturai", Ir e Molle I Ex | Completed | 15. Decedent's Educat (Specify only highest grade c | ion ompleted) | (Give | dent's Usual Occupa | during most of working | | 6b. Kind of Business | /Industry | | |
| 2 | within iene. than " | gu | Elementary/Secondary (0-12) | College (1-4or 5+) 5+ | life. | DO NOT use retired | 1) | | ma | | | |
| 7 | filed with Hygien sther the | Co | | 5+ | 1. | eacher | 18. Mother's Name | | Education | | | |
| Maryland 21215-0036 | be filed stal Hygi ed other event, I | Be | 17. Father's Name (First, Middle, Last) Stanley J. Selden | | | | Laura M. | | alden Sumame) | | | |
| yla | 2 should be i and Mental I is marked or raumatic eve | ၉ | | | O | 7.0.43 | | | | | | |
| Jar | s 1 and 2 should f Health and Men item 27 is marke other traumatic | | 19a. Informant's Name/Relationship (Type | | | • | | | City or Town, State, | | | |
| | other tra | | Kathryn L. Pickard, 20a. Method of Disposition | | | Glenside of Osition (Name of | | | rk, MD 209 | | | |
| Baltimore, | | | 1 ☐ Burial 2/10 Cremation 3 ☐ Ren | oval from State | cemetery, cres | matory or other plac | Novem | ber 10, | oo. coodnon ony o | | | |
| Ë. | tmen tant: | | * 4 □ Donation 5 □ Other (Specify) | reu | | n Crematory | 200 | | | Virginia | | |
| Sal | permit. Page Department of important: if any injury or once. | | 21. Signature of Funeral Service Licenses | 40 | | | | | Home Inc. | | | |
| | 40240 | | 23a. Pen1. Enter the disease, or complica | Jak | | | | | | Approximate | | |
| | | | shock, or heart failure. List only one | cause on each line. | iii. Do not em | er the mode of dyin | g, such as cardiae of | rospilatory arro. | st, | Interval Between Onset and Death | | |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | CONGEST | | FEART 1 | AILURE | 2 | | 72 years | | |
| | /Medical Examiner | | 1000000 | Due to (or as a consec | quence of): | | | | | | | |
| | | - | Sequentially list conditions, b | Due to (or as a consec | uence of): | | | | | | | |
| | ed sit | nin | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | ,, | | | | | | | |
| | xecur and al-trai | Examine | that initiated events c. resulting in death) Last | Due to (or as a consec | quence of): | | | | | | | |
| 8760, | The law requires that the death certificate be executed the saben signed by the attending physician and orge 2 should be detached for use as the burial-transit | ai | | | | | | | | | | |
| 687 | icate phys s the | edicai | d | | | | | | · · | | | |
| | eath certific attending p for use as 1 | Physician/Med | IF FEMALE: 23c 23c | If yes, outcome of pregn | | | | | 23d. Date of de | livery | | |
| Вох | atter I for u | clar | in the past 12 months? | 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a | | ∐Ectopic pregnancy ☐ Other (s <i>pecify)</i> | | | Month | Day Year | | |
| o. | at the de by the a | ysi | 1 ☐ Yes 2 ☑No 9 ☐ Unknown | 9□ Unknown | . 11 | | | | | | | |
| Δ. | that ned b | | Part II. Other significant conditions contri | buting to death but not res | sulting in the u | nderlying cause give | en in Part I. | 23e. Did toba | acco use contribute t | o the cause of death? | | |
| ds, | uires sign | q p | CHRONIC ATRI | AL FIBR | ILLA | TION | | 1 🗌 Yes | s 215 No 3□P | robably 4 Unknown | | |
| S | w requir been si should | lete | DEMENTIA | | | | | 24a. Was an | | utopsy findings available | | |
| of Vital Record | The lav | Completed by | 50,101 00+1 | 2126 060 | | | | autopsy | ed? death? | completion of cause of | | |
| a | | Ö | 5PINAL OSTEC | PURUSIS | _ | | 26. Place of Death | | Y | 2 2 3 1 1 0 | | |
| ⋚ | Physician: this certific ral director, | To B | examiner? | pital: 1 Inpatient 2 | ER/Outpatie | nt 3 DOA Oth | or . | | nce 6 Other (Spi | ecify) | | |
| | | | | 28a. Date of Injury (Month, Day Year) | 28b. Time o | | | | w injury occurred | | | |
| lo | th: :: Afte | atio | 1 Natural 5 Pending 2 Accident investigation | (MONTH, Day 19ar) | Injury | | Yes 2 No | | | | | |
| Division | Atter r des ector by th | ifica | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At h building, etc. (Speci | ome, farm, st | reet, factory, office | 2 | 8f. Location (Stre City or Town, | et and Number or F | ural Route Number, | | |
| ā | ial or Attending Pis after death. si after death. si Director: After ti | Certification: | 4 Hornicide | building, etc. (Speci | (y) | | | ony or rown, | Claro | | | |
| | bour hour mera y fille | | 29a. Certifier 18 Certifying Physic | ien: To the best of my kn | owledge, deat | h occurred at the tir | ne, date and place, a | ind due to the car | use(s) and manner a | s stated. | | |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | edical | (Check only 2 Medical Exemine one) | r: On the basis of examination and manner stated. | ation and/or in | | | | | | | |
| | To ti Withi To ti | × | 29b. Signature and title of certifier | A | | 29c. Licens | | | d. Date signed (Mon | ~ / | | |
| 1 | | | 1 July 14 M | / | | DO | 04158. | 7 | 11/6/3 | .006 | | |
| 5 | > | | 30. Name and address of person who com | pleted cause of death (Ite | m 23a) (Type, | | | 101 | | | | |
| | | | HELEN NOBLE | MD 122 | - SPE | ER RI | CHE | 12331 | n, nwo | ND 31630 | | |
| | Sta | | 31. Date filed (Month, Day, Year) | Registrar's Sign | ature | with the | | | 4 | | | |
| | Regist | rar | NOV 08 2006 | Marie S | 1 | 125 | | | | | | |

06-08269 Gabriel Poney

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day November 1, 2006 Medical Examiner 1520 hrs GABRIEL PONEY 4a. Facility Name (if not institution, give street and number)
14801 Pentield Circle Apt. 306 4b. City, Town, or Location of Death c County of Death Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country MOTOCCO Months Days Hours Director 1 **X** M AUGUST 3, 1933 577-58-3433 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County Yes 2 X No 28a-f show MARYLAND MONTGOMERY SILVER SPRING hours after death with the Maryland Director 10f. Zip Code 10g Citizen of What Country 23a or 28a-f notified at o 10e. Street and Numbe Pennfield United States 14801 FID CIRCLE APT. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 2 1 Never Married Married Yes 2 X No Portugal 4 X Divorced If Yes. Give Year 1 X Yes 2 No specify: Widowed WHITE à 16a. Decedent's Usual Occupation (Give kind of work done 15 Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed within 72 l th and Mental Hygiene is marked other than atic event, the Medical 21215-0036 COMPUTER PROGRAMER EDUCATION 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELIE PONEY HANNA SOUDRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Important: If item 27 injury or other traums DANIEL PONEY - SON 4705 FLOWER VALLEY DRIVE, ROCKVILLE MARYLAND 20853 20c. Location - City or Town, State 20b Place of Disposition (Name of cemetery 20a Method of Disposition Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from Stat Pages 1 GATE OF HEAVEN CEMETERY 11/6/2006 **Jepartment** Donation 5 SILVER SPRING, MARYLAND Other Specif 22. Name and Address of Facility 21 Signature of Funeral S HINES-RINALDI FUNERAL HOME, 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. Listonly one cause on each line Between Onset and /Medical Death a Hypertensive Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical UNPENDED AMENDED #6,9,10e,10g,13per FH11/17/06,BMW,McCo ttending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery Was decedent pregnant in the Year 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? igned oe deta ð 1 Yes 2 No 3 Probably 4 V Unknown Asthma, Chronic obstructive pulmonary disease Completed 24a Was an 24b Were autopsy findings available prior to completion of cause of autopsy has 2 st performed? death? certificate page Yes 2 ✓ Yes No 25. Was case referred to medical 26.Place of Death (Check only one) æ Inpatient DOA Nursing Home 5 Residence 6 ✓ Other: Scene After this ဌ 1 V Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27 Manner of Death Certification: 1 V Natural 1 Yes 2 No 5 | Pendina within 24 hours after death To the Funeral Director: the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 6 O.C.M.E. November 2, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31. Date filed (Mo Registrar's Signature State 2006 Registrar

Moises E Funes Pavon

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

| | | - For State | , | Certific | cate of Dea | th | R | eg. No. 200 | C 270C |
|---|-------------------|---|--|----------------------------------|---|--|---|---|--|
| Physician | | Decedent's Name (First, Midd | dle,Last) | | - | | 2. Date of Dea | th 400 | Time of Death |
| Medical Examin | er | Moises E | li Funes | Pavo | n | | Month Novembe | | 1152 hrs |
| | | 4a Facility Name (if not institution Prince George's Coul | | | 4b. City, | Town, or Location of verly | Death | 4c. County of Death | |
| Funeral Director | | 5. Social Security Number none | 6. Sex 7. Agr | e (In yrs. last b | irthday) If Uni Mont | der 1 Year If Under hs Days Hours | 1 | th(MM/DD/YYYY) 9. Bir 7 , 1970 Foreig | thplace (State or In Honduras Juntry) |
| = 2 5 | Director | Usual Residence of Decedent 10a. State VA. 10b. County Fa 10e Street and Number 7240 Beling 11. Marital Status 1 Never Married 2 X N | er Court 12. Was Decedent Agried Armed Forces? | Ever in U.S. | ngfield 10f. Z 2 | p Code 2150 lent of Hispanic Origin ify Cuban, Mexican, I | n? (Specify Yes or No Puerto Rican, etc.) | White, etc. | S ican Indian, Black, |
| 15-0036 filed within 72 hours after of Hygiene ad other than "natural", o | Completed by F | 3 Widowed 4 Dir 15. Decedent's Education (Spe Elementary/Secondary (0-12) | | 5+) | during most of w | No specify: 1 Occupation (Give king life, DO NOT under the contractors) | se retired) | Specify: 16b. Kind of Business/Paint | |
| d with | 탉 | 17. Father's Name (First, Middle | e, Last) | | | 18 Mother's | Name (First, Middle, | Maiden Surname) | |
| 21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica | Be | Moises Fune | s Pavon | | | | ra Pavon | | |
| MD 212' d 2 should be Ith and Menta n 27 is marke aumatic even | | 19a Informant's Name/Relation Gloria Mart | | 1 | 9b. Mailing Addres Barrio #1017, | S (Street and Numb Concepci Tequciqa | er or Rural Route Nur on 5 Ave lpa, Hon | nber City or Town State nida, 10 a duras C.A 20c. Location - City or | nd 11 Casa |
| • E E - E - E - E - E - E - E - | | 20a. Method of Disposition 1 XBurial 2 Crematio 4 Dopation 5 Other | becify: | 20b. Place crem Jard | atory or other place inas, de Suyap | Paz | 11/19/06 | Teguciga | lpa, Honduras |
| Baltime permit Page Department Important: | - 1 | 21. Signature of Funeral Se viol 23a. Part I. Eyler the disease, o | 11/1 | | PHILI 9241 | d Address of Facility P D.RINA Columbia | LDI FUNE | RAL SERVI lver Spri | CE, P.A. na Md20910 |
| Physician /Medical | Examiner | failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that imitated events resulting in death) Last | e on each line. a. Multiple Injuries Due to (or as a consum Due to (or as a consum Due to (or as a consum c | equence of): | | | | | Between Onset and Death |
| executed ian and ial - transit | | UNPENDED | d AMENDED | | | | | | |
| Box 68760, e death certificate be exe the attending physician in the attending physician of for use as the burial | sician/I | IF FEMALE: (3b) Was decedent pregnant in the past 12 months? | I LIVE DITTI | | 2 Fetal deat | | pregnancy | 23d. Date of deliver Month | y Day Year |
| P.O. | Completed by Phys | Part II. Other significant cond | itions contributing to deat | h but not result | ing in the underlyin | ig cause given in Pari | 1 Ye | prior to death? | bably 4 Unknown utopsy findings available completion of cause of |
| ital Recidian: The Is certificate? | Bec | 25. Was case referred to medic examiner? | Ulasadak | | | 26.Place of Death (0 | | | |
| Division of Vital Records, tal or Attending Physician: The law require its after death. "al Director: After this certificate has been siled in by the funeral director, page 2 should be in by the funeral director, page 2 should | P | 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Per | Hospital: 1 Inpatie | ıry 28t | Outpatient 3 Time of Injury | DOA Other 2 2 1 Yes 2 1 | Subject fell | Residence 6 Othe | r |
| Divisior lospital or Attend t hours after death uneral Director: | Certification: | 3 Suicide 6 Cou | uld not be termined (Specify) Co | nstruction | Site | ry, office building, etc | or Town, S 6216 Oxon H | ill Road, Oxon Hill, M | D |
| Di To the Hospital within 24 hours a with 24 hours a completely filled | | 29a. Certifier (Check only one) Certifying I Certifying I | Physician: To the best of maniner:On the basis of exa | y knowledge, o mination and/o | death occurred at the investigation, in r | ne time, date and plac my opinion, death occ | e, and due to the causured at the time, date | se(s) and manner as star and place, and due to th | ted ne cause(s) |
| To t with To t | Medical | 29b. Signature and title of certif | and manner stated | | | 9c. License number O.C.M.E. | | 29d. Date signed (Mo | nth, Day, Year) |
| • ' | ł | 30. Name and address of person Ana Rubio MD. As | on who completed cause of o | | | | 21201 | | |
| Sta Regist | ate | 31 Date filed (Month, Day Year | Registra | ar's Signature | freeled | | | | |

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 5:50 **Physician** 10 2006 Nov. <u>Juanita May Queen</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hagerstown

If Under Year II Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

(Month, Day, Year) Washington

9. Birthplace (State or Foreign Country) Beverly Healthcare Center 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🔯 F Feb. 24, 1903 Maryland 103 219-52-0901 Director Usual Residence of Deceden 10d. fnside City Limits 10c. City. Town or Location with the Maryland 10b. County 10a State r 28a-f ahow 1X Yes 2 No Directo Hagerstown Washington MD10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number il Hygiene. other than "natural", or Items 23a or vent, Ite Medical Examinar must be r USA 21740 750 Dual Highway death Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify **Black** Baltimore, Maryland 21215-0036 Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 6 th permit. Pages 1 and 2 should be filled a Department of Health and Mental Hygie Important: If Item 27 is marked other it any injury or other traumatic event, ILLA ONCE. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 856 W. Irvin Ave. Hagerstown, MD 21742 <u>Constance Stoner / Friend</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/14/2006 | Haperstown, MD Rose Hill Cemetery 22. Name and Address of Facility Gerald N. Minnich Funeral Home Potomac St. Hagerstown, MD 21740 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Leanens eurle Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part J δ arteroselevotie cardio. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 TYes 1 ☐ Yes 26. Place of Death (Check only one) To the Hospital or Attending Physicien:
within 24 hours after death.

FTo the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical Be Other: 4 Harsing Home 5 Residence 6 Other (Specify) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 10 ဥ 28d. Describe how injury occurred 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 27. Manner of Death Certification: 1 Hatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Peritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier un.T 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2. coffees up 424 O 32. Registrar's Signature 31. Date fifed (Month, Day, Year) NOV 13 2006 State Registrar

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

| | | | For State Registrar | | State of M | /larylan | | artmen rtificat | | | ind M | ental H | ygiene Rag. Nd | 21111 | 6 | 379 | 966 |
|--------------------------------|---|------------------|--|---|--|----------------|--------------------------------|-----------------------------|-------------------|------------------------------|------------|-------------------------------------|--|-----------------------------|-----------------------|----------------------------|--------------------|
| | Dhialai | | 1. Decedent's Name | (First, Middle, L | ast) | | | | | | | 2. Date of D | eath Da | v Y | ear | 3. Time o | f Death |
| | Physici /Medic | | Richard | | | | | | | | | Nov. 7 | 7, 20 | 06 | | 1:20 | P M |
| | Examir | er | | | ive street and number | r) | | | | r Location of | f Death | | | . County of | | | |
| | | 3 | Maplewoo 5. Social Security N | | | Ann /In um | ast birthday) | Beth If Under | | | 24 Hrs | 0. D | Montgomery | | | | |
| | Funeral Director | | 229-38-9 Usual Residence of | 010 | 1X M 2 F | 87 | Yrs. | Months | Days | Hours | Min. | 8. Date of B (Month, 2 06/16/ |) 1919 1919 | | Count ngla | | or Foreign |
| | Aaryland f ehow | or | 10a. State MD | 10b. County Montgor | nery | 1 | r, Town or Le thesda | | | | | | 10d. Inside | | | | |
| | the rate | Funeral Director | 10e. Street and Nur | nber | | | | 10f. Zip | Code | | | | 10g. Ci | tizen of Wha | t Count | ry? | |
| | h with | D | 9707 Old | George | town Rd. # | 1319 | | 20 | 814 | | | | U.S | .A. | | | |
| | deat Fra | ner | 11. Marital Status | | 12. Was Deceden Armed Forces | t Ever in U. | S. 13. | Was Deced | ent of H | ispanic Orig | gin? (Spe | cify Yes or N Rican, etc.) | 10- | 14. Race - | | | |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f ehow with injury or other traumatic event. If a Medical Exactinating an outle. | <u>م</u> | 1 Never Marri | ed 2 X Married 4 Divorced | 1 Yes 2 If Yes, Give | XNo | | 1 ☐ Yes | | Specify: | , rueno r | rican, etc.) | | Specify: | White, e Whit | | |
| 5-0 | 72 h | Completed | (Spec | 15. Decedent's ify only highest g | Education rade completed) | | 16a. Dece (Give | dent's Usua kind of wor | l Occup | ation during most d) | of workir | ng | 16b. K | ind of Busin | ess/Indi | ustry | |
| 2 | han " | ig I | Elementary/Seco | | College (1-4o | r 5+) | | | e retired | 1) | | 3 | | terna | | | |
| 2 | lled v lygie her t | | 17. Father's Name | (Eight Middle 1.2) | 5+ | | Econ | omist | | 10 Matha | d- Na | (Ci 14144 | | tary | Fund | | |
| anc | ntal H | Be | Arthur R | | 5() | | | | | | | (First, Middle) liott | ie, Maider | Sumame) | | | |
| Ž | d Me d Me mark matic | ဥ | 19a. Informant's Na | | (Type Print) | | 10b Maili | na Addross | /Stroot | | | Route Num | has City | or Town Sta | to Zie | Co do l | |
| ≥ | id 2 s th an trau | | | | ord / Wife | | | | | | | #1319 | | | | | . 4 |
| ē, | Hear tem | | 20a. Method of Disp | position | | 20b. P | lace of Dispo emetery, cre | | | | | ate | | ocation - Cit | | | |
| PE | Pages ent of nt: If i | | | Cremation 3 Other (Specific Control Contr | ☐Removal from Stat | 0 | emetery, cre cional | | | | 1/09 | /06 | Fa1 | ls Chu | ırch | V/ Δ | |
| ν≣ | mit. F partme porter / injur | | 21. Signature of Fu | | | - 1 | | | | | | eph Ga | | | | | |
| ä | Depa Impo eny is | | 1/1 | IH MI | in. | | | | | | | NW Wa | | | | | , |
| | CE Y I | | 23a. Part1. Enter th | ne discase, or co | moli ations that cause y ne cause on each | ed the death | n. Do not en | ter the mod | e of dyin | g, such as | cardiac o | r respiratory | arrest, | | | Approxima | te |
| | Physician | | Immediate Cause (| Final | | | | | | | | | | | | interval Be Onset and | Death |
| | /Medical | | disease or condition resulting in death) | n 🔏 | a. Infecto Due to (or a | | | raft | | | | | | | _ | | |
| 100 | Examiner | | | | | | 201100 01.7. | | | | | | | | | | |
| | | Je. | Sequentially list confidence in any, leading to improve cause. Enter Under Cause (Disease or | nditions, nmediate | b. Due to for a | is a consequ | uence of: | | | | | | | | | | |
| | certificate be executed adding physicien and use as the burial-transit | Examiner | that initiated events | | c. | | | | | | | | | | | | |
| ó | en ar | EX | resulting in death) I | _ast | Due to (or a | is a consequ | uence of): | | | | | | | | | | |
| 3760, | ate be nysici he bu | Icai | | | d. = | | | | | | | | | | | | |
| 39 | ing ph | Med | IF FEMALE: | I | | | | _ | | | | | | | | | |
| Вох | that the death certificined by the attending pluced by the attending pluced for use as t | Physician/Med | 23b. Was decedent | | 23c. If yes, outcom 1 ☐ Live birth | | | ⊒Ectopic pr | egnancy | , | | | | 23d. Date o | | | V |
| | the all | sici | 1 ☐ Yes 2 ☐ 9 ☐ Unknown | □No | 4□Pregnant 9□Unknown | | | Other (sp | | | | | | Month | | Day | Year |
| P.O. | law requires that the death as been signed by the atter 2 should be detached for u | Phy | | | contributing to death | but ant ann | dime in the c | | | - i- D- 41 | | 02a Dia | 4. | use contribu | | | 4 |
| Š | ires t signe | þ | | c Bowel | COMMODULING TO GRADE | Dut not 1850 | aning as the t | indenying c | anse div | enin ranti. | | | | Wase contribu | | | |
| Ö | w requires been sign should be | Completed | | | | | | | | | | | | | - | _ | |
| ec | e law has t | igh | | | | | | | | | | 24a. Wa aut | opsy | 24b. Wei | r to com | sy findings ipletion of | available cause of |
| = | cate h | | | | | | | | | | | | formed? | 1 🗆 | Yes 2 | 2 No | |
| Division of Vital Records, | Attending Physicien: Ir death. ector: After this certifica by the funeral director. p | Be | 25. Was case refer examiner? | | Hospital: | | | | Oth | | | Check only | | | _ | | |
| ot | Phys this ral di | ٠. ۲ | 1 ☐ Yes 2 🔀 | | 1 🗆 Inpa | | ER/Outpatie 28b. Time of | | A lour | V at | | ne 5 Re | | | Specify) |) | |
| on | ding h. After fune | 盲 | 1 XNatural | 5 Pending investigat | 28a. Date of In (Month, D | Day Year) | Injury | M | 8c. Injun Worl | k? Yes 2 □ N | | .ou. Describe | s now inju | ry occurred | | | |
| is. | deat ctor: y the | fica | 2 Accident 3 Suicide | 6 Could not | be One Diseased | niury - At ho | me, farm, st | | | | | 8f. Location | (Street a) | nd Number | or Rural | Route Nur | n <i>her</i> |
| ē | after after Dire | Certification; | 4 - Homicide | determine | building, | etc. '(Specif) | r) | ,, | , | | | City or T | own, State | э) | | | ,50., |
| | To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | edical C | 29a. Certifier (Check only one) | 1☑ Certifying I 2☐ Madical Ex | Physician: To the bes aminer: On the basis and manner: | of examina | wledge, deat tion and/or in | th occurred rvestigation | at the tin | ne, date and pinion, deat | d place, a | and due to the | e cause(s e, date an |) and manne d place, and | er as sta I due to | ited. the cause(| s) |
| | roth Within To th | Me | 29b. Signature and | title of certifier | | | | 290 | . Licens | e number | | | 29d. Da | ite signed (A | Month, D | Day, Year) | |
| | 2 / | | 1/1 | Te | was | 5 | | 1 | 262 | 59 | | | Nov | . 8, 2 | 2006 | | |
| 117 | | | 30. Name and addr | ess of person wh | o empleted cause of | death (Item | 23a) (Type | Print) | | | | | | | | | |
| (6 | 9) | | | | D 8218 Wi | | | | nesd | a. MD | 20 | 814 | | | | | |
| 3 | Sta | ate | 31. Date filed (Mon | th, Day, Year) | 32. Hogis | strar's Signa | | carte | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Estelle 02, 2006 Russo /Medical November 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 201 Broadwood Drive Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕅 F Months 82 Yrs. Director 578-26-0802 March 10, 1924 Washington, DC Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 X Yes 2 □ No Maryland | Montgomery Rockville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after deeth with 201 Broadwood Drive 20851 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛛 No 3 ☑ Widowed 4 ☐ Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If Item 27 is merked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Veterans Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vamakas Evaggelia Kafinakou 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Broadwood Drive; Rockville, Maryland 20851 George Russo / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Lincoln Crematory:11/13/2006 Brentwood, Maryland 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Cancer unknown primary /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physiclan and the burial-transit To the Hospital or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical ast IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 🔀 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🛭 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient P 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? efter death.

I Director: After to in by the funera Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 🙀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours e To the Funeral I ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NOV 7, 2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year) 2006 NOV 08

Cynthia M. Williams,

6001 Muncaster Mill Road, Rockville, Maryland 208 1 32 Registrar's Signature

D.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician LORRAINE EDNA ROY November 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F 84 577-24-1750 Director 8-2-1922 Virginia Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If liem 27 is marked other than "natural;" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director Prince George's Maryland 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 9203 Sheridan Street 20706 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: U.S.A. à 3 ™ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Edward Pugh Edna Blanche Stream 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Caldwell - Daughter 7711 Northern Avenue, Glenn Dale, MD 20769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 11/28/2006 Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. amino 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do held enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): MILLIA /Medical Week Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical MINGUL IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months Month 4☐Pregnant at time of death 9☐Unknown Day Year 5 Other (specify) signed by the a d be detached for P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2□ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performe con crostwo 1□ Yes 2 JN MINE 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Dippatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation (Month, Day Year) or Attending 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director. the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Asses 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 5 2006 Registrar

| | | | For State | State of Maryland | | t of Health and leath | | 711116 | 37969 |
|----------------------------|---|----------------|---|--|--|--|--|--------------------------------|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | | Certifica | e or Dearr | Reg. N | 10:- | 3. Time of Death |
| | Physicia /Medic | | MARGARET BO | enica. | KODIN | 50N | NOVEMBER | 8 2006 | 10:05 A M |
| | Examin | | 4a. Facility Name (If not institution, give s | treet and number), | | Town, or Location of Deat | | County of Deat | 7 |
| | Funeral | | 5. Social Security Number 6. Set | 7. Age (In yrs. Ia. | st birthday) If Under | NTON 1 Year If Under 24 Hrs | 8. Date of Birth (Month, Day, Yea | RINCO (| DIOROLS Applace (State or Foreign |
| п | Director | | | M 219F 73 | Yrs. Months | Days Hours Min. | August 8 | 933 MA | EULANCI |
| | and w | - | Usual Residence of Decedent 10a. State 10b. County | 10c. City, | Town or Location | | /=== | | 10d. Inside City Limits |
| | Maryl | tor | Marylant Penjag (| LANGOS BEY | MUWYDIA | 1 | | | 1 ☐ Yes 2 ☐ No |
| | or 284 | Director | 10e. Street and Number | 7072 | | Code | 10g. (| Citizen of What Co | untry? |
| | e 23a | rail | 10800 Lac Ace | as Deira | - 10 W - D - | 20613 | | USA | |
| | riter de | Funeral | 11. Marital Status 1 Never Married 2 Married | 2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No | | dent of Hispanic Origin? (S cify Cuban, Mexican, Puer | o Rican, etc.) | 14. Race - Ame Black, White | |
| 1215-0036 | filed within 72 hours after deeth with the Maryland Hygiene. Ither than "natural; or iteme 23a or 28a-f ehow on, the Medical Examinar must be notified at | þ | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | 1 ☐ Yes | 22No Specify: | | Specify: B | ack |
| 7 | n 72 h "natu edica | lete | 15. Decedent's Educ (Specify only highest grade | ation completed) | 16a. Decedent's Usu (Give kind of w life. DO NOT u | rk done during most of wo | rking 16b. | Kind of Business/ | ndustry |
| 212 | filed withi Hygiene. sther than | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | Aide | - | Ch | ARLIS COL | wty Nuesing |
| פ | be file tal Hyg d othe | Bec | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Nar | ne (First, Middle, Maid | | |
| Maryland 2 | 2 should be and Mental ie merked o | 2 | JUSCION a. Informant's Name/Relationship (Ty) | an Printl | Listap 10h Mailing Address | (Street and Number or Ri | MARIC | Wash | ington |
| | ges 1 end 2 should be filed within 72 hours after deeth with the Marylan at of Heelin and Mental Hygiens. If it lear 27 is marked other than "natural, or iteme 23a or 28a-f show it it other traumatic event, the Medical Examinar must be notified at | - | Kudalah Bohins | on/Husband | 1080010 | Aneas Dev | Beaudyw | served Assign | 1 mvd 20613 |
| altimore, | of Her of Her fitem r othe | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R | 20b. Pla | ice of Disposition (Na metery, crematory or | me of other place) | | Location - City or | |
| Ĕ | permit. Pages Department of I Importent: if its eny injury or o | | 4 □ Donation 5 □ Other (Specify) | Kas | superctio | | 17-2006 (| INTON | Maryland |
| Ba | permit. Pages Department of Importent: if i eny injury or once. | | 21. Signature of Euheral Service Ocense | 19 | 22. Name a | nd Address of Facility | lams Full | C.MARY | META |
| | | | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or | cations that caused the death. | Do not enter the mo | HYUASCO KO te of dying, such as cardia | Or respiratory arrest, | O. MAKY I | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | MKID + ONDE | 61 7-20 | | | | Onset and Death |
| Н | /Medical Examiner | | resulting in death) | Due to (or as a conseque | | | | | |
| | | ē | Sequentially list conditions, if any, leading to immediate cause for the following Cause (Disease or injury | Due/to/or as a conseque | SHOW ance of): | | | | |
| | cuted nd ransit | Examiner | that initiated events | | | | | | |
| 8760, | be exe cian a burial-i | i Ex | resulting in death) Last | Due to (or as a conseque | ence of): | | | | |
| 687 | The law requires thet the death certificete be executed the has been signed by the attending physician and bage 2 should be deteched for use es the burial-transit | edical | | | | | | | |
| Box | th certi | M/us | 23b. was decedent pregnant | 3c. If yes, outcome of pregnand 1 Live birth 2 Fetal of | | regnancy | | 23d. Date of deli | |
| П | the att | Physician/Me | in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 4☐Pregnant at time of dea 9☐ Unknown | | | | Month | Day Year |
| ۵. | thet the | y Ph | Part II. Other significant conditions con | tnbuting to death but not result | ting in the underlying | cause given in Part I. | 23e. Did tobacc | use contribute to | the cause of death? |
| Division of Vital Records, | w requires been sign should be | ed by | Depotes | | | | 1 ☐ Yes | 2 □ No 3 □ Pro | obably 4 Unknown |
| ဝင္ပ | law requires been a 2 should | Completed | ASTOLO SCH | TOTE CASAL | mandad | 1) sees | 24a. Was an autopsy | 24b. Were au | topsy findings available completion of cause of |
| <u>=</u> | The ricete h | | Read For | wer Choo. | Mc Sto | ey B | performed? | | 2□ No |
| Ħ | Attending Physician: r death. sctor: After this certifice by the funeral director. | To Be | 25. Was case referred to medical examiner? | ospital: 1 Inpatient 2 E | R/Outpatient 3 D | 04 - | ath (Check only one) Iome 5 Residence | 6 □Other (Spec | ntv) |
| 5 | ng Phy fter thi | | 27. Manner of Death 1 Natural 5 Pending | | | 28c. Injury at Work? | 28d. Describe how in | | |
| 20 | ttendii death. ttor: A the fu | cati | 2 Accident investigation 3 Suicide 6 Could not be | One Diese et leiner Arbeit | М | 1 ☐ Yes 2 ☐ No | 004 11 (Ct1 | - 111 | 7.0 |
| <u>></u> | efter Direct | Certification: | 4 Homicide determined | 28e. Place of Injury - At hom building, etc. (Specify) | ne, rarm, street, racto | у, опісе | 28f. Location (Street City or Town, Sta | | rai Houte Number, |
| | To the Hospitel or Attending Physicien: The lav Within 24 hours elter death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2 | | 29a. Certifier 1 Certifying Physical Examination (Check only 2 Medical Examination) | sician: To the best of my knowner: On the basis of examination | | | | (s) and manner as | stated. |
| | To the He within 24 To the Fu | Medical | one) 29b. Signature and title of certifier | and manner stated. | on and/or investigation | License number | arred at the time, date a | | |
| | T viii | | Zoo. Signature and the of certifier | RY 113 | 2 () | DAMAR | 290. [| Date signed (Monti | |
| < | .a | | 30. Name and address of person who co | mpleted cause of death (Item | 23a) Type, Print) | 2 440 70 | 401 | ov 8 . | 2006 |
| 7 | 0010 | | J-Fred SDA | MD | Was dore | MIN ON | | | |
| | Sta Registi | | 31. Date filed (Month, Day, Year) NOV 1 4 | 32. Refistrar's Signatu | & South | c. License number \$1001923 PMD 20 | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3) XIAM volember M Linda Carol Youngblood Richards /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Social Security Number **Funeral** 1 M 2 F Yrs. 1948 Washington DC 578-66-2431 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State or iteme 23e or 28a-f ehov other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Waldorf Maryland Charles pungitical, Linda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number US 20602 3026 Churchill Court Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail Cashier 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental Fints: If Item 27 is marked of Mary Corriber James Herman Mottley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is eny injury or other trai gnce. <u> Vincent L. Richards - Husband</u> 3026 Churchill Ct., Waldorf, MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20c. Location - City or Town, State Date 20a. Method of Disposition t X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans' Cemetery 11-17-2006 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 3035 Old Washington RD 21. Signature of Funeral Service Licensee M01391 HVdle John POB 156, Waldorf, MD 20604 Huntt Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dee to for as a consequence of Examiner anding physicien and use as the burial-transit Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by s been signer 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2₽ No Hospital or Attending Physician: 26. Place of Death Check only one 25. Was case referred to medical Other: 4 Nursing Home 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 ☐ Yes 2 😿 No 1 Anpatient 2 ER/Outpatient After this funeral of 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: Af
completely filled in by the ful 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide t 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title differ

State Registrar

2006 August 2006 31. Date filed (Month,

30. Name and address of person who completed cause

KINDIE

Avenue P.O. BOY 1317

of death (Item 23a) (Type, Print)

140

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 21, 2006 8:17 AMM **Physician** Amos Irvin Renn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Northampton Manor Nursing Home Il Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept. 29, 1910 9. Birthplace (State or Foreign Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1**∑**M 2□F Hours Months 96 214-34-0758 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State il Hygiene. , other than "netural", or Itama 23a or 28a-1 error. rvent, tra Medical Examinar must be notified at 1XX es 2 □ No Frederick Frederick Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21701 U.S.A. 615 Magnolia Avenue Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. filed within 72 hours after 1 □Yes 2 X No If Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 X Vidowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Livestock Dealer Cattle permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Importent: if Item 27 is marked other It any injury or other fraumatic avent. ILA once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elmira Coblentz John S. Renn 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5433 Shookstown Road, Frederick, MD 21702 Mr. Irvin D. Renn, son 20b. Place of Disposition (Name of cometery, crematory or other place, Mount Olivet Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Nourial 2 Cremation 3 Removal from State Nov. 25, 2006 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney and Basford PA Funeral Home 21. Signature of Funeral Service Licensee MO0255 ruchan 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Causè (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Certification: To Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Į Month Day Year 5 Other (specify) signed by the et t be detached for 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1□Yes 22No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Des certificate 1□ Yes 2 No Pass 25. Was case refer to medical examiner the funeral director, 26. Place of Death (Check only one) Hospital: Other: 20 No Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death After Natural 2 Accident 5 Pending 1 Yes 2 No death. investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide rx Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Hile of certifier, November 21, 2006 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple Frederick, MD 31. Bate liled (Month, Day, Year, egistrar's Signature State Registrar

ORIGINAL

Physician /Medical Examiner requires that the death certificate be executed Box 68760. P.O. Records,

or Vital

Division

or Attending

Hospital

Physician/Medical Examiner burial-trai physician the burial as attending signed by i P After 1 death. I Director: d in by the f within 24 hours a To the Funeral I

9

Completed

Be

Certification:

Medical

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ral", or items 23a or Examiner must be r

natural

than

item 27

Department or Important: If any injury or

1 and 2 should be Health and Mental and Mental

Pages 1 = 5 Director

Funeral

Completed by

Be

ဂ္

MD

filed within 72 hours after death with the Maryland I Hygiene.

Maryland 21215-0036

Baltimore,

Sequentially list conditions, it cays. Enter Underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CRYPOCOCCAL MENINGITIS CLOSTRIDIUM 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

29c. License number

70064560

29d. Date signed (Month, Day, Year)

12

NOVEMBER

ROCKVILLE

2006

MARYLAND 20850

NIKHANI MD. NIDHI

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

9901 MEDICAL CENTER DRIVE 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23a,25,27,28b,d,f,per ME,C863,01/23/07dhb,Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Year Forrest Gallatin Stouffer /Medical November 112006 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital If Under 24 Hrs. Hours Min. Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Nov 11 **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F Days Yrs Director 30 217-23-1018 Montana Usual Residence of Decedent 10a. State 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Washington 1X Yes 2 □ No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò pe 1334 Woodland Way or items 23a 21742 Funeral U.S.A. traumaffic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 X No þ White 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hyglene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Chef Resturaunt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert L. Stouffer 2 Linda A. Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2: tment of Health a Robert L. Stouffer (father) 1334 Woodland Way Hagerstown Maryland 21742 of Disposition (Name of 20c. Location - City or Town, St. Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State D partment of In portant: If it 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury Smithsburg Crematory 11-18-06 Smithsburg Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Multiple Injuries disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner to (or as a consequence of) The law requires that the death certificate be executed ON APPROVED BY MEDICAL for use as the burial-trar resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical CERTIFICAT IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year P.O. 5 ☐ Other (specify) been signed by the a should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy this certificate or Vital 1□ Yes 2 No Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28d. Describe how injury occurred pedestrian 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Division 1 Natural Injury 5 Pending ours after death.

neral Director: A
filled in by the fu investigation 2 Accident 8106 1:06 1 ☐ Yes 2 ☐ Nostruck by car Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

5 to etc.

28f. Location (Street and Number or Rural Route Number, City or Town, State) Mt. Aetna Rd near (Lager) + Council Street and Number, City or Town, State) Mt. Aetna Rd near (Lager) + Council Street and Number, City or Town, State) Mt. Aetna Rd near (Lager) + Council Street and Number, City or Town, State) Mt. Aetna Rd near (Lager) + Council Street and Number, City or Town, State) Mt. Aetna Rd near (Lager) + Council Street and Number or Rural Route Number, City or Town, State) Mt. Aetna Rd near (Lager) + Council Street and Number or Rural Route Number, City or Town, State) Mt. Aetna Rd near (Lager) + Council Street and Number or Rural Route Number, City or Town, State) Mt. Aetna Rd near (Lager) + Council Street and Number or Rural Route Number, City or Town, State) Mt. Aetna Rd near (Lager) + Council Street and Number or Rural Route Number, City or Town, State) Mt. Aetna Rd near (Lager) + Council Street and Number or Rural Route Number, City or Town, State) Mt. Aetna Rd near (Lager) + Council Street and Number or Rural Route Number, City or Town, State) Mt. Aetna Rd near (Lager) + Council Street and Number or Rural Route Number, City or Town, State) Mt. Aetna Rd near (Lager) + Council Street and Number or Rural Route Number, City or Town, State) + Council Street and Number or Rural Route Number, City or Town, State) + Council Street and Number or Rural Route Number, City or Town, State) + Council Street and Number or Rural Route Number, City or Town, State) + Council Street and Number or Rural Route Number, City or Town, State) + Council Street and Number or Rural Route Number or Rural Route Number, City or Town, State) + Council Street and Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rura 6 ☐ Could not be 3☐ Suicide 4 Homicide 0 within 24 hours a

To the Funeral I 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier Malley, MI) 29c. License number 29d. Date signed (Month, Day, Year) D0050813 10/10/ 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mayer Suita 17 mash 600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 4 2006

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Ga:254 Vovember 13 20do Virginia Lee SMITH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F Director 81 220-28-3897 Feb. 21 1925 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 361 Little Antietam Drive 21740 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🛛 No 1 ☐ Yes 2 ☑ No Specify: Completed by 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician Medical Lab 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ William Francis Hamill Mattie Dietz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7124 Rockcreek Drive, Frederick, Md. 21702 Pam Kendrick - Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 tment of I rtant: If It t Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Pages Department or Important: If I any Injury or once. Rose Hill Cemetery 11/17/06 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home fred Vesta 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence 1) Examiner Cardio M Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 0,50056 CHYDNAYY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No. 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

use for

ed by the a detached f signed by has page 2 certificate this funeral After Hospital or Attending ithin 24 hours after death.

the Funeral Director: Afformpletely filled in by the fur

attending physician

To th. within 2. 0H-5

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 1 4 2006

29c. License number DO 60396

ipal

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

CM.

21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARID

SHED MUR

32. Registrar's Signature parket

| | | | For State Registrer | State o | f Marylai | | artment rtificate | | | and M | lental Hy | giene Reg. No. | 006 | | 3797 | 6 |
|----------------|---|----------------------|--|---|--|---|---|----------------------------|---------------------------------------|-----------------------|---|--------------------|---------------------------------------|--------------------|---|---------|
| | Physici | | 1. Decedent's Name (First, Middle Constance | | 3 | | | | | | 2. Date of De Month NOV • | ath Day 10 | 2 ^{Yea} | 6 | 3. Time of Death 6:10 P | |
| | Examir | er | 4a. Facility Name (If not institution Julia Manor 5. Social Security Number | • | e Cent | | 4b. City, To | Hage | Location o | wn | | | County of De Washi | ngt | | |
| | Funeral Director | | 130-34-0924 Usual Residence of Decedent | 1 M 2 XF | 7. Age (In yrs. | | | Days | Hours | Min. | 8. Date of Bird (Month, Da Aug 31 | y Year) 19 | 43 | irthpla Country | PA | ign |
| | e Maryland te-f show | ctor | MD 10b. County Wasi | nington | 10c. C | ity, Town or Lo | Hagers | stow | 'n | | | | | 100 | l. Inside City Limi 1X Yes 2 ☐ N | |
| | ath with th | rai Director | 10e. Street and Number 53 Broadway | | | | 10f. Zip C | 217 | | | | | en of What 0 | | | |
| 980 | 72 hours after death with the Maryland natural', or Itams 23s or 28e-f show disal Examiner (ust be publiked at | i by Funerai | 11. Marital Status 1 □ Never Married 2 □ Marria 3 □ Widowed 4 █ Divorced | Armed Fo | / 0 | | Was Deceder If Yes, specify 1 ☐ Yes 2 | - | spanic Orig n, Mexican Specify: | gin? (Spe , Puerto | ecify Yes or No- Rican, etc.) | | 4. Race - Am Black, Wh Specify: | ite, et | | |
| 21215-0036 | within ene. then | Completed | 15. Deceden (Specify only highe Elementary/Secondary (0-12) 11 | t's Education st grade completed) College (| 1-4or 5+) | (Give | dent's Usual (kind of work DO NOT use Beautic | done du retired) | uring most | of worki | ng | 16b, Kir | od of Busines | | , | |
| Maryland 2 | 2 should be fited and Mental Hygi is marked other raumatic evant, I | To Be C | 17. Father's Name (First, Middle, Earl R. Cook | Last) | | | | | | | yn D. B | | | | | |
| | and 2 sho lealth and m 27 is ma her trauma | | 19a. Informant's Name/Relations Jean Baraclou | | ster | 53 | Broad | lway | | t. 3 | , Hager | stow | n, MD | 217 | 40 | |
| Baltimore, | permit. Pages 1 Department of H Important: If Ita any injury or otl | | 20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 4 □ Donation 5 □ Other (S | pecify) | State | Place of Dispo cemetery, crer nberlar | natory or other | er place Ley | Crem | 11/ | | Wa | ynesbo | ro, | PA | |
| Ba | permi Depa Impo any ir | | 21. Signature of Funeral Service 23a. Part1. Inter the disease, or | Beners | aused the dea | | 50 S. | Bro | ad St | t. Wa | aynesbo | ro, | Funer PA 172 | 68 | Home, In | nc. |
| | Pnysician /Medical Examiner | Examiner | snock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury that initiated events | aDue to | end line. (or as consec | quence of): | ni lu | | | | . rospilatory di | | | l r | iterval Batween inset and Death 2 0 | |
| .O. Box 68760, | that the death certificate be executed ed by the attending physician and delached for use as the burial-transit | Physician/Medical Ex | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | d | irth 2 ☐ Feta ant at time of c | ancy | Ectopic preg | | | | | 2 | 3d. Date of de Month | blivery | ay Year | |
| s, D | quires that n signed by uld be deta | by | Part II. Other significant condition | ons contributing to de | eath but not res | sulting in the u | ndertying cau | se giver | n in Part I. | | | | e contribute i | | cause of death? | ٧n |
| Vital Record | iiclan: The law requires that the certificate has been signed by th rector, page 2 should be detache | e Completed | 25. Was case referred to medical | | | | | | | | | sy med? 2 No | 24b. Were a prior to death? | comp | r findings availab letion of cause of | ie I |
| of | Phys this aldii | Certification: To Be | examiner? 1 Yes 2 No 27. Manner of D ath 1 Natural 5 Pendin 2 Accident Investig | g 28a. Date (Montigation | npatient 2 confinition of the co | ER/Outpation 28b. Time of Injury | | Other Injury a Work? | 4 Nur | sing Hon 2 | Check onl or ne 5 ☐ Resid 28d. Describe h | ence 6 | | ecify) | | |
| Division | vitel or Att urs after de rel Direct | | 3 Suicide 6 Could a determ | ined 286. Place | of Injury - At h ng, etc. (Specii | ome, farm, str | eet, factory, o | ffice | | 2 | 8f. Location (S City or Tow | | Number or A | urai A | oute Number, | |
| | To the Hospitel or Attanding I within 24 hours after death. To the Funarel Director: After completely filled in by the funer | Medical | 29a. Certifier (Check only one) 2 Medical 29b. Signature and title of certifier | | best of my kno asis of examina ner stated. | owledge, death ation and/or inv | restigation, in | my opia | nion, death | place, a | ed at the time, o | late and p | lace, and du | e to th | e cause(s) | |
| } | Mi TC | | 1 02 | | | - 00-1 7 | 4 | _ | 232 | 3 | | | signed (Mon | | r, rear) | |
| 01 | 4-3 | | 30. Name and address of person Khalid M. Wase 31. Date filed (Month, Day, Year) | em 1 | 1260 O _I | al Cou | rt, Ha | ger | stown | , ME | 21740 | | | | | |
| Kr | Sta Registr | | NOV 1 | 4 2006 | gistrar's Signa | B. A | rele | | | | | | | | | |

| | | | 1 - For State Registrar | State of Mar | yland / Dep <i>Ce</i> | artment of F rtificate of | lealth and l <i>Death</i> | | ene 006 | 37977 |
|------------|---|---------------------|---|--|-----------------------------------|---|--|--|-----------------------------------|--|
| | Physici | | Decedent's Name (First, Middle, Lat ELWOOD LUTHER | eugene swa | IN | | | 2. Date of Death Month | Day Year | 3. Time of Death |
| | /Medic Examin | | 4a. Facility Name (If not institution, give WASHINGTON COUNT | | | | Location of Death | h | 4c. County of Dea | |
| | Funeral Director | | 5. Social Security Number 6. S 220–18–0143 | 87 · 4 - C - | ln yrs. last birthday) 82 Yrs. | Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day,) | 1924 9. Bi | rthplace (State or Foreign Output) MARYLAND |
| | nyland thow | _ | Usual Residence of Decedent 10a. State 10b. County | 1 | Oc. City, Town or Lo | ocation | | | | 10d. Inside City Limits |
| | the Ma | recto | MARYLAND WASHT | NGTON | | HAGEF | RSTOWN | 100 | J. Citizen of What C | 1 ∑Yes 2 □ No |
| | 23e or | ral Di | 1183 LUTHER DRIV | • | | 2 | 21740 | | Ţ | J.S.A. |
| 980 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23e or 28e-f show sayl injury or other traumatic event, it a Medical Exartifiar must be notified at ance. | by Funeral Director | 11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced | 12. Was Decedent Eve Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: | 1943- 13. 1946 | Was Decedent of H If Yes, specify Cuba 1 Yes 2 No | ispanic Origin? (S in, Mexican, Puert Specify: | pecify Yes or No- o Rican, etc.) | 14. Race - Am Black, Whi | |
| 21215-0036 | in 72 ho n "natur dedical | Completed | 15. Decedent's Ed (Specify only highest gra | ide completed) | (Give | dent's Usual Occup kind of work done DO NOT use retired | during most of wor | king 16 | Sb. Kind of Business | s/Industry |
| | iled with tygiene. her the | | Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last) | College (1-4or 5+) | SI | CATIONARY | ENGINEE | ER | | MANUFACTURE |
| Maryland | Mental Parked of | To Be | BERTRAM EARL SWA | | | | | ET MAY COR | | |
| | nd 2 sho eith and 27 ie mu | | 19a. Informant's Name/Relationship (BETTY JANE SWAIN | | 19b. Maili 1183 | ng Address <i>(Str</i> eet) B LUTHER I | and Number or Ru DRIVE # 5 | 004, HAGER | City or Town, State, STOWN, MA | Zip Code) ARYLAND 2174 |
| Baltimore, | Pages 1 a ment of Her lant: if Item lury or othe | | 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification) | Removal from State | | osition (Name of matory or other place O CEMETEI | | | BOONSBORC | Town, State), MARYLAND |
| Ball | Depart Depart Import eny in | | 21. Signatur of Fune tal Service Licer | nsee , | 2: | 2. Name and Addres BAST FUNI | | i. | NATIONAL O, MARYLA | |
| | | 0. 7 | 23a. Part Fore the disease, or com- shock, or heart failure. List only Immediate Cause (Final | one cause on each line. | | _ | - | | | Approximate Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) | a. Tan en | | Carcin | loma | * | | iraouth. |
| | Examiner | er | Sequentially list conditions, if any, reading to immediate | b. Due to (or as a c | onsequence of). | | | | | |
| | secuted end d-transit | xamlr | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a c | onsequence of): | | | | | |
| 8760, | icate be executed physicien end s the burial-transit | dical Examiner | | d. | | | | | | |
| | Attending Physician: The law requires thet the death certific ar death. sctor: After this certificate has been signed by the ettending p. etter this certificate has been signed by the funeral director, page 2 should be detached for use as | by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of 1 □Live birth 2 □ 4 □ Pregnant at tim | Fetal death 3 | □Ectopic pregnancy □ Other (specify) | | 4. | 23d. Date of de Month | livery Day Year |
| rds, P. | w requires thet been signed b should be deta | | Part II. Other significant conditions o | ontributing to death but r | not resulting in the u | inderlying cause giv | en in Part I. | | | o the cause of death? robably 4 20Unknown |
| al Reco | n: The law re icate has be r. page 2 sho | Completed | | | | | | 24a. Was an autopsy performe 1 Yes 20 | prior to | utopsy findings available completion of cause of |
| ř Vit | hysiciar nis certii I directo | To Be | 25. Was case referred to medical examiner? 1 Tes 2 No | Hospital: Inpatient | 2 ER/Outpatier | nt 3 DOA Oth | 0.0 | th Check only one ome 5 Residence | ce 6 ⊡Other (Spe | ecify) |
| o uo | nding PI th. : After tl s funera | tlon: | 27. Manner of Death Natural 5 Pending Accident investigation | 28a. Date of Injury (Month, Day Yo | / at (? Yes 2 □ No | 28d. Describe how | injury occurred | | | |
| - | F B F C | Certification; | 3 Suicide 6 Could not be determined | 28e. Place of Injury building, etc. (| - At home, farm, str Specify) | reet, factory, office | | 28f. Location (Stre City or Town, | et and Number or R State) | ural Route Number, |
| | To the Hospital or Attending Physician: The law within Fuhanus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | edical | (Check only 2 Medical Exan | ysician: To the best of n niner: On the basis of ex and manner stated | rred at the time, date | and place, and du | e to the cause(s) | | | |
| } | To t Com | ž | 29b. Signature and title of certifier | g Shop | | 29c. License | 28365 | 290 | Date signed (Mont | th, Day, Year) |
| خاک | 1-5+1 | | 30. Name and address of person who | completed cause of eat | h (Item 23a) (Type, | Print) | agento | wn 217 | 142 | |
| | Sta Registr | | 29b. Signature and title of certifier JUNION 30. Name and address of person who MAWZAR. J. J. 31. Date filed (Month, Day, Year) NOV 1 4 2 | 32. Registrar's | Signature | and I | T | , ((| | |

| _ | | | 1 - For State Registrer | State of Ma | ryland | | ment of H | | d Mental I | lygien Reg. N | 7001 | 37978 |
|----------------------------|---|-------------------|--|--|---------------------------------------|-------------------------------------|---|--------------------------------------|---------------------------------------|---------------------------|-------------------------------------|--|
| | Physici | an | 1. Decedent's Name (First, Middle, | , | | | | | 2. Date of Month | | ay Year | 3. Time of Death |
| | /Medi | | | Sklar | | | | | Nov 5 | | | 10:12am M |
| | Examir | ner | 4a. Facility Name (If not institution, | | | 4 | b. City, Town, or | | eath | | c. County of Dea | |
| | Funeral Director | | Sunrise Assited 5. Social Security Number 577-16-6306 | | | | Rockvil f Under 1 Year Months Days | If Under 24 h | lin. (Month | Birth Day, Yea. | | thplace (State or Foreign ountry) |
| | pu . | | Usual Residence of Decedent 10a. State 10b. County | | 10c City | Town or Locat | ion | | | | | |
| | Aaryla Pohor | ក | · · | omery | | hesda | ion | | | | | 10d. Inside City Limits 1√2 Yes 2 □ No |
| | 28a- | Funeral Director | 10e. Street and Number | , | | | 10f. Zip Code | | | 10g. C | itizen of What C | 21 |
| | h with | | 5225 Pookes Hi | .11 Rd | | | 2081 | L4 | | | ited Sta | - |
| | deat | ner | 11. Marital Status | 12. Was Decedent E Armed Forces? | ver in U.S | . 13. Wa | s Decedent of Hes, specify Cuba | ispanic Origin? | (Specify Yes or | No- | 14. Race - Am | |
| Maryland 21215-0036 | tiled within 72 hours after death with the Maryland Hygiene. titler than "naturel", or Iteme 23a or 28a-f ehow ant, the Medical Examinar must be rotified at | | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 Yes 2 No If Yes, Give Year or Dates: | 0 | | Yes 21 No | Specify: | ieno rican, etc. | | Black, Wh | White |
| 2-0 | 72 ho | eted | 15. Decedent's (Specify only highest | | | 16a. Deceden | t's Usual Occupa d of work done o NOT use retired | ation during most of i | working | 16b. | Kind of Business | Andustry |
| 2 | vithin han | Completed by | Elementary/Secondary (0-12) | College (1-4or 5- | +) | Store (| | 1) | | | | Coode |
| i i | s 1 and 2 should be filed withi f Heelth and Mental Hygiene. Item 27 ie marked other than other treumatic evant, the M | S | 17. Father's Name (First, Middle, La | let) | | Store | Owner | 18 Mother's N | Name (First, Mic | | porting | Goods |
| and | d be f | 9 Be | | isiy | | | | | | | in Sumame) | |
| <u> </u> | 2 should be f and Mental h ie marked of reumatic eva | ပ္ | Louis Sklar 19a. Informant's Name/Relationship | (Type, Print) | | 19b. Mailing A | Address (Street a | | e Freund Rural Route Nu | | or Town, State, | Zip Code) |
| ₹ | old 2 27 is | | Susan Goldsteir | /Daughter | | | Culver S | | | | | |
| Je, | tem item | | 20a. Method of Disposition | | 20b. Pla | | on (Name of ory or other plac | | Date | - | Location - City o | Town, State |
| € Ë | Page nent c | | 1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | | | | d Mem Pa | | - 7 - 06 | Fa1 | ls Churc | ch, VA |
| A Baltimore, | permit. Pages 1 and 2 Department of Heelth a Important: If Item 27 le eny Injury or other treu 2002. | | 21. Signature of Funer in Service Lie | censee | | 22. N | ame and Addres | ss of Facility J | oseph Ga | awler | 's Sons | INC |
| ш | 20559 | | W. Certing | Mung | | 51. | 30 Wisco | onsin A | ve,N.W. | Wash | ington l | |
| 90, | Physician /Medical Examiner purial-transit | I Examiner | 23a. Part1. Enter the disease, are conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Cardiac Due to (or as a b. Coronar Due to (or as a c. Due to (or as a | Arrh conseque V Art conseque | nythmia ence of): ery Dis | | | | | | Interval Between Onset and Death |
| P.O. Box 68760, | requires that the death certificate be executed een signed by the ettending physicien and nould be deteched for use as the burial-transit | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | d | Fetal o | leath 3□Ec | topic pregnancy ther (specify) | | | | 23d. Date of de Month | livery Day Year |
| | s that | by P | Part II. Other significant condition | s contributing to death but | t not result | ting in the unde | rlying cause give | en in Part I. | 23e. C | id tobacco | use contribute t | o the cause of death? |
| ğ | w require been sig should b | ed | Hypthyroidism | | | | | | _ 1 | ☐ Yes 2 | 2 □ No 3 □ P | robably 4 Unknown |
| 90 | as as as as as as as as as as as as as a | ple | | | | | | | 24a. V | ↑as an utopsy | 24b. Were a | utopsy findings available completion of cause of |
| Ä | The ete he | Completed | | | | | | | 1 Ye | erformed? | death? | s 2 No |
| /ita | Physician: The lav this certificate hes ral director, page 2 | Be (| 25. Was case referred to medical examiner? | | | | | | Death (Check or | | | |
| Ę, | hysic this c | ဥ | 1 ☐ Yes 2 № No | | | R/Outpatient | | 4 🗆 Nursini | | | | Assited |
| Division of Vital Records, | After After | Certification: | 27. Manner of Death 1 ♣ Natural 5 ☐ Pending 2 ☐ Accident investigal 3 ☐ Suicide 6 ☐ Could no | | | 28b. Time of Injury | | rat c? Yes 2 □ No | | | ury occurred | Living |
| Divi | Ital or At its efter o rel Direct led in by | Certifi | 4 Homicide determina | building, etc. | | | | | City or | Town, Sta | te) | ural Route Number, |
| | To the Hospital or Attentwithin 24 hours effer death To the Funerel Director: completely filled in by the | Medical | 29a. Certifier 1 Certifying (Check only one) | Physicien: To the best of eminer: On the basis of e and manner state | examinatio | ledge, death od on and/or invest | curred at the tim tigation, in my op | ne, date and pla pinion, death or | ace, and due to courred at the tir | the cause(ne, date ar | s) and manner a nd place, and du | s stated. e to the cause(s) |
| | | Σ | 29b. Signature and title of certifier | 10 | 9 | MA. | 29c. License | | | | ate signed (Mon | * |
| | Ee | | 1 John | w/h | ld | (IN) | D0011 | .921 | | No | ov 6,200 | 16 |
| | - | | 30. Name and address of person wi | | | | | | | | | |
| | Ctr | 10 | Dr. John Galot 31. Date filed (Month, Day, Year) | | okes | Hill Ro | , Bethe | sda,MD | 20814 | | | |
| | Sta Registr | | NOV 08 | 32 Registrar | H | 1004 | 2.8 | | | | | |

State of Maryland / Department of Health and Mental Hygier [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month **VIRGINIA** SWIFT November 13, 2006 3:23 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death McCready Memorial Hospital Crisfield Somerset 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months 1 ☐ M 2 🂢 F Director Yrs. 76 214-38-3118 February 6, 1930 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r then "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26556 Mariners Road 21817 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any lollury or other treumatic event, sone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emma Nora Trader Samuel Preston Hinman ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26556 Mariners Road - Crisfield, Maryland 21817 <u>Donald Lee Swift (Husband)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridge Memorial Park 11/16/06 4 ☐ Donation 5 ☐ Other (Specify) Crisfield, Maryland 21. Signatura of Funeral Society Rights of Mary Beth Bradshaw-Pruitt 22. Name and Address of Facility Bradshaw & Sons Funeral Home <u> 306 West Main Street - Crisfield, Maryland 21817</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Obstruc **Physician** D-W /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed anding physician and use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Completed by Physician/Medical attending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2 No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No 1□ Yes 2NNo Division of Vital To the Hospitel or Attending Physicien: Nimin 24 hours after death.
To the Funeral Director: After this certificel Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ٩ 1 Inpatient 2 NER/Outpatient 3 DOA : After this tuneral 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 Yes 2 No f Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D54422 SARAD R. BARAL, MU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pocom 32. Regarar's Signature 31. Date filed (Month; Day; Year) 😇 State Registrar 6 2006

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2006

14

| | | 1 - For State Registrer | State of Mary | • | artment of I | | | Reg. No. | | 7981 |
|---|------------------|--|---|---|--|--------------------------------|--|-------------------------------|--|-------------------|
| Physici | an | Decedent's Name (First, Middle, Last | | | | | Month | Day | Year | ime of Death |
| /Medi | | SHEILA 4a. Facility Name (If not institution, give | STEELE | | 4b. City, Town, | or Location o | NOV. | 40,000 | 2006 3: | 35 A ^M |
| Examir | ner | HOLY CROSS HOS | | | | ER SPE | | | ONTGOMERY | • |
| Funeral | | 5. Social Security Number 6. Se | | yrs. last birthday, | If Under 1 Year | If Under 2 | 24 Hrs. 8. Date of Bir | th | 9. Birthplace (| State or Foreign |
| Director | | 217-29-5085 | □M 20XF 6 | 1 Yrs. | Months Days | Hours | Min. (Month, Da FEB. 12 | , 1945 | TRINI | DAD |
| yland now | | 10a. State 10b. County | 100 | c. City, Town or L | ocation | | | | 10d. Ins | side City Limits |
| Mar. | tor | MD. MONTGOME | ERY | | SILVER SP | RING | | | 1[| Yes 2 ₹No |
| th the | Funeral Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen | of What Country? | |
| ath w | rai [| 2932 HEWITT A | AVE. | | | 20906 | | | RINIDAD | |
| tems tems | une | 11. Marital Status | 12. Was Decedent Ever Amed Forces? | in U.S. 13. | Was Decedent of I If Yes, specify Cub | Hispanic Orig oan, Mexican | gin? (Specify Yes or No , Puerto Rican, etc.) |)- 14. i | Race - American Ind Black, White, etc. | lian, |
| ire, Maryland 21215-UU36 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, tiem 27 ie marked other then "natural; or items 23s or 28s-f show other treumatic event, the Medical Examinational Landilled at | by | 1 Never Married 2X Married 3 Widowed 4 Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | | 1 ☐ Yes 2 X No | Specify: | | Spe | ecify: BLACK | |
| 5-C | etec | 15. Decedent's Edi (Specify only highest grad | | 16a. Dece (Give | edent's Usual Occu e kind of work done DO NOT use retire | pation during most | of working | 16b. Kind o | f Business/Industry | |
| within Markin | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | | DO NOT use retire URSING AS | | | MIIDCT | NG HOME | |
| filed v Hygie other | ပိ | 8 17. Father's Name (First, Middle, Last) | | IN | DESTING WE | 1 | r's Name (First, Middle, | | | |
| Maryland of 2 should be file lith and Mental Hy 27 Is marked oth treumatic event | Be | LEWIS | GRANT | | | | GLADYS | | ENE | |
| aryiance should be to and Mental to marked of umatic eve | 5 | 19a. Informant's Name/Relationship (7) | | 19b. Mail | ing Address (Stree | t and Numbe | r or Rural Route Number | | |) |
| and 2 | | CLAUDIA GRANT/S | SISTER | 2932 | HEWITT A | VE., 5 | SILVER SPRI | NG, MD | . 20906 | |
| TOFE, | | 20a. Method of Disposition | 2 | 0b. Place of Disp | | | Date | | on - City or Town, St | ate |
| 0 00 | | 1 ☐ Burial 2 Toremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify, | | - | | | 1-16-2006 | RIVE | RDALE, MD | |
| baltimo permit. Pag Department importent: I eny Injury o | | 21. Signature of Funeral Service Vicens | 600 | 2 | 2 Name and Addr | ess of Facility | v | | | |
| 20 20 2 3 | | MM. Chan | noruse M | 00091 5 | 801 CLEV | FUNEKA ELAND | L HOME & Cl AVE., RIVE | RDALE, | MD.20737 | |
| Physician /Medical Examiner | Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | a. METASTATI Due to (or as a co METASTATI Due to (or as a co CARDIOMYO | nsequence of): C ENDOME nsequence of): PATHY | | NCER | | | | |
| icate be executed physicien and sthe burial-transit | Icai | resulting in death) Last | Due to (or as a co | nsequence of): | | | | | | |
| ecords, P.O. Box 68/60, law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown | 23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown | Fetal death 3 | □Ectopic pregnanc □ Other (specify) _ | Çy | | 23d. | Date of delivery Month Day | Year |
| IS, P | by Pt | Part II. Other significant conditions co | ntributing to death but no | t resulting in the i | underlying cause gr | ven in Part I. | | _ | ontribute to the caus | |
| COLD W requir been si should | ted | | | - | | | | Yes 2∟No | 3 Probably | 4 XUnknown |
| HECOTGS, The law requires tate has been signe | Completed | | | | ., | | 24a. Was autop perfo | osy ormed? | b. Were autopsy fin prior to completio death? 1 \(\sum \text{Yes} \) 2 \(\sum \text{N} \) | on of cause of |
| | Bec | 25. Was case referred to medical examiner? | | | | 26. Place | of Death (Check only | | | |
| or VITA Physician: this certific ral director, | 2 | 1 ☐ Yes 2 👿 No | Hospital: 1X Inpatient | 2 ER/Outpatie | ent 3□ DOA Ot | her: 4 ☐ Nu | rsing Home 5 🗆 Resi | dence 6 🗆 | Other (Specify) | |
| ding After | | 27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation | 28a. Date of Injury (Month, Day Yea | ar) 28b. Time (| Wo | ıryat ork?]Yes 2.∐1 | 28d. Describe | how injury oc | curred | |
| 2 2 3 3 3 3 3 3 3 3 3 3 | Certification; | 3 Suicide 6 Could not be determined | 28e. Place of Injury - building, etc. (S | At home, farm, si pecify) | treet, factory, office | | 28f. Location (. City or To | | mber or Rural Route | e Number, |
| Hospital 24 hours a Funeral (letely filled | edical | 29a. Certifier 1 Certifying Phy (Check only one) | rsician: To the best of my iner: On the basis of exa and manner stated. | knowledge, dea mination and/or in | th occurred at the t nvestigation, in my | ime, date and opinion, deat | d place, and due to the the courred at the time, | cause(s) and date and plac | manner as stated. ce, and due to the ca | ause(s) |
| To the within 2 To the complet | Me | 29b. Signature and title of certifier | | | 29c. Licen | se number | | 29d. Date siç | ned (Month, Day, Y | 'ear) |
| 5 | | > hubithelo | 1 | | חסת | 062520 | | NOA | . 13, 2000 | 6 |
| | | 30. Name and address of person who d | ompleted cause of death | (Item 23a) (Type | | JULJEU | | 1404 | . 13, 2000 | • |
| | | MARIA D'ARBE | LLA, M.D. | 1500 F | OREST GL | EN RD. | , SILVER SI | PRING, | MD. 20910 | 0 |
| Sta | ate | 31. Date filed (Month, Day, Year) | nc 32 Registrar's S | Signature | culis | | | | | |

| | | | 1 - For State Registrar | State of I | Marylan | id / Depa | artmer rtificat | nt of H te of L | ealth a Death | and Me | ental Hy | giene | 2006 | 379 | 82 |
|-------------------|--|-------------------|---|--|-------------------------|----------------------------------|------------------------------|----------------------|---------------------|--------------|-------------------------------|--------------------|--------------------------|---|------------------|
| | | | 1. Decedent's Name (First, Middle, La | ist) | | | | | | 1 | 2. Date of De. | ath Day | / Year | 3. Time of De | eath |
| | Physici /Medi | | Willie Mae Sh | arpe | | | | | | 1 | | | 2, 2006 | | 7a ^M |
| | Examir | | 4a. Facility Name (If not institution, giv | | er) | • • • | 4b. City, | Town, or | Location o | of Death | | 4c. | County of De | ith | |
| | | | Southern Maryla | nd Hospit | al | | (| Clint | on | | | Pr | ince Ge | orges | |
| | Funeral | | · · · · · · · · · · · · · · · · · · · | Sex 7 1 ☐ M 2 ☑ F | Age (In yrs. | last birthday) | If Under Months | r 1 Year Days | If Under 2 Hours | 24 Hrs. | 8. Date of Birt (Month, Da | h y, Year) | 9. Bi | thplace (State or Fountry) | oreign |
| н | Director | | 377 44 0310 | 1 | 87 | Yrs. | | | | 1 | Nov.5, | 191 | 9 Lake | City, S | .C. |
| | pue s | | Usual Residence of Decedent 10a, State 10b. County | | 10c. Cit | ty, Town or Lo | cation | | <u> </u> | | | - | | 10d. Inside City I | Limits |
| | Aaryli Seho | ō | District | | | ashing | | | | | | | | 1 XYes 2 | |
| | 28a- | Director | Columbia 10e, Street and Number | | | | 10f. Zip | Code | | | | 10a Citi | izen of What C | ountry? | |
| | With and | 2 | | | _ | | 101. 24 | | 010 | | | - | ited Si | • | |
| | leath | Funeral | 3771 Jay Street N | 12. Was Decede | nt Ever in U | .S. 13. | Was Dece | | 019 spanic Orio | ain? (Spec | rfv Yes or No | | 14. Race - Am | | |
| | fier d | Fu | 1 Never Married 2 Married | Armed Force | s? | | | | n, Mexican | , Puerto R | rfy Yes or No ican, etc.) | | Black, Wh | te, etc. | |
| 936 | urs a | þ | 3 ☐ Widowed 4 ☐ Divorced | 1 Tes 21 If Yes, Give Year or Date | s: | | 1 🗌 Yes | 2√€ No | Specify: | | | | Specify:B1 | ıck | |
| 21215-0036 | tiled within 72 hours after death with the Maryland Hygiene. Ather then "naturel", or itema 23a or 28a-f show ant, the Medical Examinar must be notified at | Completed | 15. Decedent's E | ducation | | 16a. Dece | dent's Usu | al Occupa | ition | | | 16b. Ki | ind of Busines | /Industry | |
| 218 | P. C. | ple | (Specify only highest grant (0-12) | College (1-40 | or 5+) | | | | | t of working | 9 | P | rivate | | |
| 2 | gien er th | Son | 8 | | | До | mest | LC WO | rker | | | | | | |
| pu | al Hy al Hy a oth | Be | 17. Father's Name (First, Middle, Last | ") | | | | | 18. Mothe | r's Name (| First, Middle, | Maiden | Sumame) | | |
| <u>×</u> | Meni Meni | 2 | Benjamin Rious | | | | | | Ett | ta U | nknown | | | | |
| Maryland | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23s or 28s-f show any injury or other traumatic avant, the Medical Exaction must be notified at once. | | 19a. Informant's Name/Relationship (| | | | - | | | | | | r Town, State, | | |
| | and ealth T 27 | | Willie James Sha | arpe / Son | | | | | | | | | ro, Md | | |
| Baltimore, | of H of H or oth | | 20a. Method of Disposition | Removal from Sta | 20b. F | Place of Dispo cemetery, crer | nsition (Name natory or o | me of other place | a) ; | Da | te | 20c. Lo | cation - City o | Town, State | |
| Ë | Pag ment ant: | | 4 ☐ Donation 5 ☐ Other (Special | (y) | | rmony | | | | 1/17/ | | | dover, | | |
| all | Depertition Depertition of the properties of the | | 21. Signature of Funeral Service Lice | nsøe | | 22 | Alexa | nd Addres | s of Facility | y Pone | Eunera | 1 Ho | mes. P | A·20747 | |
| Ш | 205 29 | | The City | Stery or | 1 0/ 08 | | | | | | | | Te, Md | 20747 | |
| п | | | 23a. Part 1. Enter the disease, or com shock, or heart failure. List only | plications that cause on each | sed the deat n line. | h. Do not ent | er the mod | de of dying | , such as | cardiac or | respiratory ar | rest, | | Approximate Interval Between | en |
| | Physician | | Immediate Cause (Final disease or condition | , Au | te my | 10 card | al | Into | eritia | 4 | | | | Onset and Dea | atn |
| | /Medical | | resulting in death) | Due to (or | as a cons | uence of): | | | | | | | | | |
| | Examiner | | Sequentially list conditions. | b | | | | | | | | | | | |
| | p is | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or | as a conseq | uence of): | | | | | | | | | |
| | The law requires that the death certificate be executed ate been signed by the attending physician and page 2 should be detached for use as the burial-transit | cam | that initiated events resulting in death) Last | C. Due to /or | | | | | | | | | | | |
| 8760, | cian cian | | | Dag to (or s | as a conseq | derice or): | | | | | | | | | |
| 87 | cate t | Physician/Medical | • | d | | | | | | | | | | | |
| 9 | ding p | Me | IF FEMALE: | 23a If was autoor | no of program | | | | | | | | | | |
| Box | ath c | lan | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcor 1☐Live birth | 2 Feta | ldeath 3□ | Ectopic p | | | | | 1 | 23d. Date of de Month | livery Day Yea | ar |
| | the s | ysic | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 4☐Pregnant 9☐Unknowr | | leath 5L | Other (sp | oecity) | | | | | | ĺ | |
| P.0 | w requires that the death certific been signed by the attending pi should be detached for use as i | | Part II. Other significant conditions | contributing to death | n but not res | ulting in the u | ndertving a | cause give | n in Part I. | | 23e. Did to | obacco u | ise contribute | o the cause of dear | th? |
| of Vital Records, | signe d be | Completed by | End Stack Ken | . / / | u ! | Hemoi | light | Mad | Deren | dut | | res 2 | / | robably 4 Dunk | |
| Ö | requipeen | ete | | | | / | 1 | 77010 | 1 | | - | | | | |
| 3ec | has has | E G | | | | | | | | | 24a. Was autop | an sy med?_/ | 24b. Were a | utopsy findings ava completion of caus | allable se of |
| a | r: Th | | | | | | | | | | | 2 No | 1 ☐ Ye | 2 1 No | |
| Ζ | Physician: this certificantal director, | Be | 25. Was case referred to medical examiner? | Hospital: | | | | Othe | | | Check only o | | | | |
| of | Phys this ral di | 70 | 1 ☐ Yes 2 ☑ No 27. Manner of Death | 1 Inpa | | ER/Outpatien 28b. Time of | | JA | 4 LI NUI | | e 5 🗌 Resid | | 6 □Other (Sp. | ocify) | |
| u | ding h. After fune | ion | 1 ☑Natural 5 ☐ Pending | (Month, I | Day Year) | Injury | M | 28c. Injury Work | ai ′es 2.∐.N | | d. Describe i | iow irijar | y occurred | | |
| Division | Attending it death. ector: Atterby the fune | Certification: | 3 ☐ Suicide 6 ☐ Could not b | OB Bloom of | Injury - At he | ome farm str | | | 03 2 1 | | If Location /5 | Street an | d Number or F | ural Route Number | |
| Ò | or A effer Direction by | erti | 4 Homicide determined | | etc. (Specif | | eer, racios | y, onlog | | 20 | City or Tox | | | urai noule ivumbei | , |
| _ | To the Hospital or Attending Physician: The I within 24 hours eiter death. Jo the Funeral Director: After this certificate ha completely filled in by the funeral director, page | | 29a. Certifier Certifying Pl | hysician: To the be | st of my kno | wledge desti | n occurred | at the tim | e date an | d place an | id due to the | rause/s\ | and marror | e stated | |
| | a Hos 24 h Fur etely | Medical | (Check only 2 Medical Examone) | miner: On the basis and manner | s of examina | ition and/or in | vestigation | i, in my op | inion, deat | th occurred | at the time, | date and | place, and du | e to the cause(s) | |
| | of the | ₩ Me | 29b. Signature and other of certifier | | | | 29 | c. License | number | | | 29d. Dat | e signed (Mon | th, Day, Year) | |
| | - 310 | | > Nahu | · · | 1 | | | 100 | 5512 | .0 | | 1/12. | 1 13 2 | JTV | |
| | (3) | | 30. Name and address of person who | | 7 | n 23a) (Tune | | | | | | 1000 | | 00 | |
| | Offe | | Rich and Pilme | MI) 13 | 28 .În. | hum 1 | EN A. | 31. | Sunt | 1. 310 | wah | 1.16 | tun Dr | 20032 | |
| | Sta | ate | 31, Date filed (Month, Day, Year) | 32. Regi | strar's Signa | tur | | | | _ | | 1 | - 1 | 7 - 0 = | • • • • • • • |
| | Regist | | NUV 15 ZUUD | seem 18. | 1 | | | | | | | | | | |

| hysici/Medic | | 1 - State Registrer 1. Decedent's Name (First, Middle, La | | | | | 2. Date of De | ath | | 3. Time of Death |
|---|-----------------------------|--|---|---|--|--|---|--|---|---|
| AUGUSTON | | Saloma Schrock | | | | | Novembe | er 14, | Year 2006 | 3:50 P ^M |
| Examir | | 4a. Facility Name (If not institution, giv | e street and number) | | 4b. City, Town, or | Location of | Death | 4c. Coun | ty of Death | |
| | | Goodwill Mennonit | te Home | | Grantsvi | lle | | Garr | ett | |
| uneral rector | | 5. Social Security Number 220–03–7576 | Sex 7. Age (In) 1□ M 2\ 7. \ 7. \ 9. | yrs. last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hours | Min. 8. Date of Bi | 1913 | 9. Birthp Coun Penn: | lace (State or Foreign sylvania |
| * | | Usual Residence of Decedent 10a. State 10b. County | 10c | . City, Town or Lo | ocation | | | | 1 | 0d. Inside City Limits |
| 9 9 | 5 | | | cantsvil | | | | | | 1 □ Yes 2 No |
| 28a- | Director | MD Garret | L GL | .aiicsvii. | 10f. Zip Code | | | 10g. Citizen o | f What Coun | itov? |
| 0 8 | | | DA | | 21536 | | | USA | | , |
| 10 Z | Funeral | 891 Dorsey Hotel 11. Marital Status | 12. Was Decedent Ever i | | Was Decedent of H | ispanic Origin | n? (Specify Yes or N | - | ace - Americ | an Indian, |
| 른칅 | F. | 1 Never Married 2 Married | Armed Forces? 1 ☐ Yes 2 XNo | | If Yes, specify Cuba | | Puerto Rican, etc.) | | ack, White, | |
| o'ig | b | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | 1 ☐ Yes 2 🛣 No | Specify: | | Spec | "'y" Whit | :e |
| r than "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at | Completed | 15. Decedent's E (Specify only highest gra | | (Give | dent's Usual Occup | during most o | of working | 16b. Kind of | Business/Ind | dustry |
| than 7 | dr | Elementary/Secondary (0-12) | College (1-4or 5+) | | DO NOT use retired | 1) | | ~ - II | | |
| ther th | Ö | 3 | | Homem | aker | 40 14-45-4 | - No Crista Adiddi | Own H | | |
| 0 2 | Be | 17. Father's Name (First, Middle, Last, | , | | | | s Name (First, Middle | , Maiden Suma | ame) | |
| narke natic (| ပ္ | Asa Schrock | Constant | 40h 44- (| | | Bender | O't T. | - 0 7 | 0-4-1 |
| raun Traun | | 19a. Informant's Name/Relationship (June L. Opel/Nei | ** * | | • | | or Rural Route Numb Albright, 1 | | | Code) |
| f Itam 27 ie marked r other traumatic e | | 20a. Method of Disposition | | Db. Place of Dispo | | 0 0/ 2 | Date Date | 20c. Location | | wn. State |
| int: If its | | 1 🖾 Burial 2 ☐ Cremation 3 ☐ | Removal from State | cemetery, cre | matory or other place | | ov. 18, 200 | | | |
| ntant njury | | 4 □Donation 5 □ Other (Specifical Signature of Fugeral-Service Lice | , | | | | Newman Fu | | | |
| Important: If eny injury or goce. | N 19 | De Lyun | Deuma | . / | | | antsville | | 1536 | F.A. |
| | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused the cone cause on each line. | death. Do not en | ter the mode of dyin | g, such as ca | ardiac or respiratory a | rrest, | | Approximate Interval Between |
| sician | | Immediate Cause (Final disease or condition | - Proumo | NIA | | | | | | Onset and Death |
| edical miner | | resulting in death) | Due to (or as a con | | - 7 5 | ~ | | · | | |
| cı | ē | Sequentially list conditions, | , GANGR | ENE | OF F | 007 | | | | |
| isit | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a con | STT//C | 11100 | (0) | | | | |
| sician and burial-transit | Examin | that initiated events resulting in death) Last | c. Due to (or as a con | | ULLE | 1 | | | _ | |
| hysician a the burial- | icai E | | | | | | | | | |
| phy as the | | | _ u. | | | | | | | |
| ittending ph or use as th | Physician/Med | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pre | | Teacio processor | | | 23d. D | ate of delive | nry |
| | icia | in the past 12 months? 1 ☐ Yes 2 ☒ No | 1 Live birth 2 1 4 Pregnant at time | | □Ectopic pregnancy □ Other (specify) | | | ٨ | Month | Day Year |
| 5 2 | hys | 9 Unknown | 9□ Unknown | | | | | | | |
| by | by P | Part II. Other significant conditions of | contributing to death but not | t resulting in the u | inderlying cause give | en in Part I. | 23e. Did | tobacco use co | | e cause of death? |
| 2 2 2 | | | | | | <u> </u> | 1_ | Yes 22(No | 3 ☐ Prob | ably 4 □Unknown |
| signed d be de | | | | | | | 24a. Was | an 24t | . Were auto | psy findings available inpletion of cause of |
| s been signed 2 should be de | pie | | | | | | | ormed? | death? | 2□ No |
| s been s 2 should | Comple | | | | | | pert 1 ☐ Yes | ormed? 28 No | 1 ☐ Yes | 2 🗆 140 |
| ificate has been signed or, page 2 should be de | Be Completed | 25. Was case referred to medical | | | | | perf 1 ☐ Yes of Death (Check only | | 1 1 1 1 1 1 1 1 | |
| is certificate has been signed director, page 2 should be de | | examiner? 1 ☐ Yes 2 X No | | 2 ☐ ER/Outpatie | | er: 🕰 Nurs | | опе) | | |
| this certificate has been signed al director, page 2 should be de | To Be | examiner? | Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea | | of 28c. Injun | er: 42 Nurs y at k? | ing Home 5 Res | опе) | ther (Specify | |
| After this certificate has been signed uneral director, page 2 should be de | To Be | examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Yea | 28b. Time of Injury | of 28c. Injun Work | er: 🕰 Nurs | of Death (Check only cling Home 5 - Res 28d. Describe | one) idence 6 🗆 o | ither <i>(Specif</i>) urred | ·) |
| irector: After this certificate has been signed n by the funeral director, page 2 should be de | To Be | examiner? 1 Yes 2 No 27. Manner of Death X Natural 5 Pending | 28a. Date of Injury (Month, Day Yea | 28b. Time of Injury At home, farm, st | of 28c. Injun Work | er: 42 Nurs y at k? | of Death (Check only sing Home 5 Res 28d. Describe 28f. Location | one) idence 6 🗆 o | ither <i>(Specif</i>) urred | |
| Irector: After this certificate has been signed n by the funeral director, page 2 should be de | Certification; To Be | examiner? 1 | 28a. Date of Injury (Month, Day Yea | 28b. Time of Injury At home, farm, stoecify) | of 28c. Injun World 1 reet, factory, office | er: 4X Nurs y at k? Yes 2 □ No | ing Home 5 Res 28d. Describe 28f. Location City or To | one) idence 6 □ 0 how injury occi Street and Nur wn, State) | ther (Specify urred nber or Rura | r) I Route Number, |
| Irector: After this certificate has been signed n by the funeral director, page 2 should be de | Certification; To Be | examiner? 1 | 28a. Date of Injury (Month, Day Yea 28e. Place of Injury building, etc. (Sp hysician: To the best of my miner: On the basis of exar | At home, farm, st | of 28c. Injun World M 1 □ | er: 4X Nurs y at k? Yes 2 No | ing Home 5 Res 28d. Describe 28f. Location City or To | idence 6 00 how injury occions/Street and Nur wn, State) | other (Specify urred Inber or Rura manner as st | I Route Number, |
| irector: After this certificate has been signed n by the funeral director, page 2 should be de | To Be | examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation 3 Suicide 4 Homicide | 28a. Date of Injury (Month, Day Year building, etc. (Sp. hysician: To the best of my | At home, farm, st | of 28c. Injun World M 1 □ | er: 4 Nurs y at k? Yes 2 No | ing Home 5 Res 28d. Describe 28f. Location City or To | idence 6 00 how injury occions/Street and Nur wn, State) | other (Specify urred niber or Rura manner as st a, and due to | // // Route Number, lated. the cause(s) |
| After this certificate has been signed uneral director, page 2 should be de | edical Certification; To Be | examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation 3 Suicide 4 Homicide Could not be determined 29a. Certifier (Check only one) Certifying Property Medical Example Property Certifying Property Medical Example Property Property Medical Example Property Prope | 28a. Date of Injury (Month, Day Yea 28e. Place of Injury building, etc. (Sp hysician: To the best of my miner: On the basis of exar | At home, farm, st | 28c. Injun Work M 1 reet, factory, office h occurred at the tin vestigation, in my o | er: 42 Nurs y at k? Yes 2 No | of Death (Check only ing Home 5 Res 28d. Describe 28d. Location City or To place, and due to the occurred at the time | idence 6 00 how injury occilination of the state of the s | ther (Specify urred inber or Rura manner as st e, and due to ned (Month, | I Route Number, lated. I the cause(s) Day, Year) |
| irector: After this certificate has been signed n by the funeral director, page 2 should be de | edical Certification; To Be | examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation 3 Suicide 4 Homicide Could not be determined 29a. Certifier (Check only one) Certifying Property Medical Example Property Certifying Property Medical Example Property Property Medical Example Property Prope | 28a. Date of Injury (Month, Day Yea 28e. Place of Injury building, etc. (Sp. hysician: To the best of my miner: On the basis of exar and manner stated. | At home, farm, st opecify) At home, farm, st opecify) I knowledge, deat mination and/or in | 28c. Injum Worl M 1 reet, factory, office h occurred at the tim restigation, in my o | er: 4 Nurs y at k? Yes 2 No | of Death (Check only ing Home 5 Res 28d. Describe 28d. Location City or To place, and due to the occurred at the time | idence 6 00 how injury occilination of the state of the s | other (Specify urred niber or Rura manner as st a, and due to | I Route Number, lated. I the cause(s) Day, Year) |
| irector: After this certificate has been signed n by the funeral director, page 2 should be de | edical Certification; To Be | examiner? 1 | 28a. Date of Injury (Month, Day Yea 28e. Place of Injury building, etc. (Sp. hysician: To the best of my miner: On the basis of exar and manner stated. | At home, farm, st pecify) At home, farm, st pecify) At home, farm, st pecify (Item 23a) (Type, | 28c. Injun World M 1 1 reet, factory, office th occurred at the time to the restigation, in my or 29c. Licens: | er: Will Nurs y at k? Yes 2 No ne, date and pinion, death e number | Death (Check only ing Home 5 Res 28d. Describe 28d. Location City or To 28d. and due to the occurred at the time | idence 6 □ 0 how injury occ (Street and Nur wn, State) cause(s) and a date and place | ther (Specify urred inber or Rura manner as st e, and due to ned (Month, | I Route Number, lated. I the cause(s) Day, Year) |

| • | | | 1 - For State Registrar | State of M | | | | ealth and M | lental Hyg | iene | 27005 |
|-------------------|--|---------------------|--|--|-------------------------|---------------------------------------|----------------------|---|---------------------------------|---|--|
| | | | 1. Decedent's Name (First, Middle | Lastl | | Certificate | OT D | veatn | 2. Date of Deat | ng. Nd. UUU | 3. Time of Death |
| ı | Physic /Medi | | | gart Stew | vart | | | N | ovembe | Day Year | |
| | Exami | | 4a. Facility Name (If not institution | | | | | ocation of Death | | 4c. County of Death | |
| | | | 7010 Masons 5. Social Security Number | | e (In yrs. last birti | | P1a | ta If Under 24 Hrs. | 8. Date of Birth | Charle | |
| В | Funeral Director | | 245-38-2182 | 1□M 21XF | 0.5 | | Days | Hours Min. Decen | ber I | 3,1923 Wa | place (State of Foreign ntry) Shington |
| | www | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town | or Location | | | | | 10d. Inside City Limits |
| | Maryl I sho | tor | MD C | harles | 1 | Plata | | | | | 1 ☐ Yes 2 ☐ No |
| | or 28s | Olrec | 10e. Street and Number | | 1 | 10f. Zip C | Code | 646 | 10 | Og. Citizen of What Cou | ntry? |
| | a 23a | rail | 7010 Masons | | | | | | | USA | |
| 21215-0036 | be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or itama 23a or 28a-f ahow avent, I're Madical Examinat must be notified at | by Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced | 12. Was Decedent Armed Forces? 1 □ Yes 2 ▼ 1 f Yes, Give Year or Dates: | | 13. Was Decede If Yes, specif | y Cuban, | panic Origin? (Spe , Mexican, Puerto I Specify: | cify Yes or No- Rican, etc.) | 14. Race - Ameri Black, White, Specify: Whi | etc. |
| 5-0 | "natu | letec | 15. Decedent (Specify only highes | s Education t grade completed) | | Decedent's Usual Give kind of work | done dui | ion ring most of working | ng | 16b. Kind of Business/In | dustry |
| 72 | e filed within al Hygiene. I other than " | Completed by | Elementary/Secondary (0-12) | College (1-4or 5 | | iife. <i>DO NOT u</i> se Educato | | | | Public S | chools |
| ng | be filed Ital Hygi od other | BeC | 17. Father's Name (First, Middle, L | | | | 1 | 8. Mother's Name | | faiden Sumame) | |
| yla | should be nd Mental marked o matic ava | To I | Otho Carl Sh | | | | | Nancy F | | | |
| Maryland | end 2 sh salth and n 27 ia m | | 19a. Informant's Name/Relationsh Jerry Stewart | | 19b. | Mailing Address (3 010 Mas | Street and | Springs | Route Number, Rd. L | City or Town, State, Zip a Plata, M | D 20646 |
| ore, | ges 1 en it of Heal if item 2 or other | | 20a. Method of Disposition | | 20b. Place of I | Disposition (Name crematory or other | of | , D | | 20c. Location - City or To | |
| Baltimore, | permit. Pages 1 end 2 should Department of Health and Men Important: if Item 27 is marke any injury or other treumatic. ance. | | 1- Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp | ecify) | 01d Du | | | ery 11/ | 22/06 | Ironsides | ,MD |
| Ba | permit. Page Department important; if any injury of | | 21. Signature of Funeral Service L | icensee | M00945 | | | | | HOME, P.A | |
| | | | 23a. Part1. Enter the disease, or a shock, or heart failure. List of | complications that caused | the death. Do no | t enter the mode | of dying, | lary's F such as cardiac o | Ve. La r respiratory arre | Plata,MD | Approximate Intervat Between |
| 58760, | Physician be executed by physician and Examiner but site private its the priva | dical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Sevi-to Due to (or as | a consequence of | ifstu | las lu | truck | ufrin Ul | ing Dis | Onset and Death USA News |
| _ | ntificat ng phy s as th | | IF FEMALE: | 1 | | | | | | | |
| .O. Box | The law requires that the death certifical has been signed by the attending lage? Should be detached for use as | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown | 2 Fetal death | 3 ☐ Ectopic preg 5 ☐ Other (spec | | | | 23d. Date of delive Month | ery Day Year |
| Records, P. | w requires that been signed b should be deta | þ | Part II. Other significant condition | s contributing to death bu | ut not resulting in t | he underlying cau | se given | in Part I. | 23e. Did toba | acco use contribute to the | |
| _ | | Completed | 25. Was case referred to medical | | | | | | | ed death? ☐ No 1 ☐ Yes | psy findings available inpletion of cause of |
| Division of Vital | nysicia nis cert direct | To Be | examiner? | Hospital: 1 ☐ Inpatie | nt 2□ ER/Outp | atient 3 DOA | Laur | 26. Place of Death 4 □ Nursing Hom | | ice 6 Other (Specify | () |
| ٥ 2 | ding Pt h. After th funeral | | 27. Manner of Death 1. Natural 5 Pending | 28a. Date of Injur (Month, Day | y 28b. Tir Year) Inj | | . Injury at Work? | | 8d. Describe hov | | 7 |
| <u>s</u> | Attendi death. ctor: A y the fu | licati | 2 Accident investigation inves | ot be 280 Place of lai | ıry - At home, fam | M | | s 2 No | 06.1 | | .= |
| 2 | s after or Al | Certification: | 4 ☐ Homicide determin | building, etc | . (Specify) | i, sileet, lactory, c | HICE | 2 | City or Town, | eet and Number or Rura State) | Houte Number, |
| | To the Hospitel or Attanding Physicien: within 24 hours after death. Its certification the Funeral Director. After this certification is the funeral director. | Medicai (| 29a. Certifier Certifying (Check only 2 Medical E | Physician: To the best of xaminer: On the basis of | examination and | death occurred at | the time, | date and place, a | nd due to the cau | use(s) and manner as st | ated. |
| | To the within 2 To the complet | Med | 29b. Signature and title of certifier | and manner sta | ted. | A | icense n | | | d. Date signed (Month, I | |
| | r s r ö | | TANK | 1577 | Cm | 1 |) 2 | 2017 | G | 1 1 7 | 01116 |
| | 10 | | 30. Marke and address of person w | no completed cause of de | eath (Item 23a) (T | pe, Print | . ~ | 110 | | | 7.00 |
| 500 | Sta | to | 31. Date filed (Month, Day, Year) | Registre | And Aris Signature | MN | 17, | NA | LDON | JYL VY LIX | 20603 |
| | Registr | | 44- | 2006 de la | J. J. | barle | | | | | |
| DHM | /IH 17 Rev 1/20 | 001 | | | - | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Gertrude Eulalie Sames November 18 2006 10:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Genesis Eldercare-Spa Creek Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 M 2 F 214-12-3949 09/21/1920 Director Maryland 86 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits r than "natural", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Anne Arundel Harwood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 85 South River Clubhouse Road 20776 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed by 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important; if them 27 is markad oth any linity or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eulalie Skinner William Herbert Bradford, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 85 South River Clubhouse Rd., Harwood, Maryland 20776 Thomas E. Sames, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Hallows Church Cemetery 11/21/2006 Harwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 100 Ull 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) Physician WW seps 15 weeks /Medical Due to (or as a consequence of): Examiner Horive. Fail we to Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregpant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? þ sete has been signe page 2 should be DVI 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No. Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2∏ No 1 Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: Certification: To 1 Inpatient Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Mannes of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No М investigation 2 ☐ Accident eftar death Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ş

0

State Registrar 29b. Signature and title of certifier

R-RDVas

Desai

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

2006

2108 DiDonato Drive, Chester, Maryland 21619

29c. License number

00061688

29d. Date signed (Month, Day, Year)

11/19

| • | | | | partment of Health and Mertificate of Death | lental Hygie | 2000 | 37987 |
|------------|---|------------------|--|--|--|----------------------------|---|
| | Physici | an | Decedent's Name (First, Middle, Last) | | 2. Date of Death Month | Day Vear | 3. Time of Death |
| | /Medic | | Reva Lela Sanders | | November | ^{Day} 2006 | 7:40 PM |
| 1 | Examir | er | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | |
| | Europel | | Somerford Place 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) | Annapolis // If Under 1 Year If Under 24 Hrs. | 8. Date of Birth | Anne Arur | nde1 |
| ŀ | Funeral Director | | 120-16-4023 | Months Days Hours Min. | 08/08/19 | 9ar) Col. 24 New | York |
| | pu , | | Usual Residence of Decedent | | 00,00,17 | | |
| | ehov | 'n | 10a. State 10b. County 10c. City, Town or L | cocation | | | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No |
| | the N | ect | Maryland Anne Arundel Edgewater 10e. Street and Number | 10f. Zip Code | 100 | Citizen of What Cou | |
| | 3a or | IDI | 2316 Briarcroft Court | 21037 | | ited State | |
| | deaft | Funeral Director | 11. Marital Status 12. Was Decedent Ever in U.S. 13. | . Was Decedent of Hispanic Origin? (Spe | cify Yes or No- | 14. Race - Amen | |
| 9 | be filed within 72 hours after death with the Maryland tal Hyglene. d other than "neture!", or iteme 23e or 28e-f ehow event, the Medical Exantien must be notified at | / Fu | Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, G: 2 ☒ No If Yes, Give | If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2X No Specify: | Rican, etc.) | Black, White | |
| 21215-0036 | ure!; | d by | 3 Mildowed 4 Divorced Year or Dates: | | | Specify: Bla | |
| 5 | in 72 | Completed | (Specify only highest grade completed) (Giv | edent's Usual Occupation e kind of work done during most of workii DO NOT use retired) | ng 16b | o. Kind of Business/Ir | ndustry |
| 212 | d with piene. | mo | Elementary/Secondary (0-12) College (1-4or 5+) | Bank Teller | Ba | anking | |
| b | be filed tal Hygi d other | BeC | 17. Father's Name (First, Middle, Last) | 18. Mother's Name | | | |
| <u>X</u> | should b and Ment marked umatic e | To. | Isaac Taylor | Mable Mau | ıde Josepl | h | |
| Maryland | | | | ling Address (Street and Number or Rura | | | p Code) |
| | 1 and Health em 27 thar t | 3 | Jo-Ann Henry Espeut/Niece 2316 20a. Method of Disposition 20b. Place of Disp | Briarcroft Court, E | | | |
| Ď | ages of of of t: If it | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State | amatory or other place) | | c. Location - City or T | |
| altimore, | permit. Pages 1 and 2 Department of Health s Important: If item 27 is eny injury or othar tra | i | the state of the s | | | gewater, M | |
| B | Depa Impo eny ir | IJ | DIM 1/1/1/ | 2. Name and Address of Facility Geo 1973 Solomons Island | orge P. Ka | alas Funer | al Home |
| 20 | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. | nter the mode of dying, such as cardiac or | r respiratory arrest, | ewater, rib | Approximate |
| | Physician | ĺ | A 2 | 1 theimer's a | 1.000 | 16 | Interval Between Onset and Death |
| | /Medical | | resulting in death) Due to (or as a consequence of): | 1 Herriers a | girer) | 1)09 | years |
| | Examiner | | Sequentially list conditions, b. | | | | |
| J | led Isit | Examine | If any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | |
| | al-fra | xan | that initiated events resulting in death) Last C. Due to (or as a consequence of): | | | | |
| 8760, | cate be executed physician and the burial-fransit | dical | d | | | | |
| Ó | death certificate be executed e attending physician and id for use as the burial-fransit | ledi | | | | | |
| Вох | eath certifi attending for use as | an/N | IF FEMALE: 23b. Was decedent pregnant in the cast 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 | □Ectopic pregnancy | | 23d. Date of delive | ery |
| | | Physician/Me | | Other (specify) | | Month | Day Year |
| ď. | ires that the de signed by the a I be defached | P. | Part II. Other significant conditions contributing to death but not resulting in the u | underlying cause gives in Rest I | 220 Did tobacc | co use contribute to the | h |
| Records, | law requires that the as been signed by th 2 should be defache | d by | and the second s | andenying cause given in Fait i. | 1 Yes | | |
| ဂ် ဝ | w require been signal | lete | | | 24a. Was an | | |
| r | The lar | ompieted | | | autopsy performed | prior to co death? | ppsy findings available impletion of cause of |
| Vital | | 0 | 25. Was case referred to medical | 26. Place of Death | (Check only one) | No 1 □ Yes | 2 No |
| > 0 | Z 20 | 2 2 | examiner? 1 Yes 2 106 Hospital: 1 Inpatient 2 ER/Outpatient | 0 | | 6 Cther (Specif | VI LIVI |
| | ing Ph Viter th uneral | - 1 | 27. Mann of Death 1 atural 5 Pending 28a. Date of Injury (Month, Day Year) Injury | | 8d. Describe how in | | 8 |
| DIVISION | Attending r death. ector: After by the fune | cati | 2 Accident investigation 3 Suicide 6 Could not be an of laws. | M 1 Yes 2 No | | | |
| = | if or Atten after deat Director: I in by the | Certification; | 4 Homicide determined determined 28e. Place of Injury - At home, farm, st building, etc. (Specify) | reet, factory, office 2 | 8f. Location (Street City or Town, St | and Number or Rura ate) | al Route Number. |
| | Hospital of 24 hours at the Funeral Diefely filled in | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat | h occurred at the time, date and place, at | nd due to the cause | a/s) and manner as s | tatod |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer | edicai | (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. | vestigation, in my opinion, death occurre | d at the time, date a | and place, and due to | the cause(s) |
| | To the within 2 To the complet | | 29b. Signature and title of certifier | 29c. License number | 29 d . l | Date signed (Month, | Day, Year) |
| | 1 | | 1/ | 1D D507 | 25 1 | 11-24 | -2006s |
| | 5 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, | Print) | 11.11 | // / | 11 21 |
| | 0 | | 31. Date filed (Month, Day, Year) 32. Degistrar's Signature | Print) D507 | U, Uers | ville/ | 10 d/108 |
| | Stat Registra | | 31. Date filed (Month, Day, Year) 32. pegistrar's Signature | meles of | | | |
| | | | NIIV Z M ZUUD JUNE NIIV | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Harry Emmett Slusher, Jr. 4:25 AM 2006 premper 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours Director 217-12-1025 Jùn 15, 1924 Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

The m 27 is marked other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show other than marke event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits MD Washington 1 ☐ Yes 2 No Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe o 14719 Daley Road 21740 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 X Yes 2 No If Yes, Give 43-46 Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Interior decorator Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry E. Slusher, Sr. Gertrude Evelyn Brown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald F. Slusher brother 101 3rd St., Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of He
Important: If Iten
any injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State Mt Zion Cemetery 11/24/2006 Quincy, PA 17247 4 Donation 5 Other (Specify) 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc 21. Signature of Funeral Service Licensee 50 S. Broad St. Waynesboro, PA 17268 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -ardiopulmonary **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit oli that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) been signed by the a should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an cate has t autopsy performed? Yes 2 No certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

NOV 2 9 2006

Medi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11110

egistrar's Signature

1) 5826

Campus Rd

| | เท | Decedent's Nar | JAMES | | TT. SH | ARP | | | | | | | 2. Date of Month | | Day 2006 | Year | 3. Time of |
|--|--|--|--|--------------------------|--|---|---|--|--|--|---|-----------------|--|--|--|--|--|
| /Medica xamine | | 4a. Facility Name | | | | | | | 4b. City, | Town, or | Location | of Death | UCI. | 10, | 4c. County | | |
| | Ý. | MEMORIA | L HOSP | ITAL | | | | | CUM | 1BERI | AND | | | | ALL! | EGAN | Y |
| neral ector | | 5. Social Security 232-62-7 | | 6. Sex | : M 2□F | | (In yrs. las | st birthday, Yrs. |) If Under Months | r 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of (Month, FEB . | Birth Day, Ye 20 | 1941 | 9. Birth Cot MAI | nplace (State ountry) RYLAND |
| | - | Usual Residence | 7 | | | | | | | | | | | | | | |
| S TE DE | | 10a. State | MORG/ | | | | | Town or L W PAW | | | | | | | | | 10d. Inside C |
| roufied at | Funeral Director | 10e. Street and No | | 314 | | | 111 | 1111 | 10f. Zip | Codo | | | | 100 | Citizen of V | Alban Oa | |
| 1 1 1 | ā | | | A STERNI | me | | | | | 5434 | | | | Tog. | USA | Minat Col | untity r |
| THE | era | 11. Marital Status | COOLE A | | 12. Was De | cedent Ev | er in U.S. | . 13. | | | ispanic Or | igin? (Sp | ecify Yes or Rican, etc.) | No- | | e - Amer | rican Indian, |
| of name 25s | 교 | | rried 2. Mar | | Armed | Forces? s 2 ⊟ No | 1964 | | | | | | Rican, etc.) | | Blad | ck, White | e, etc. |
| Exp | t by | 3 Widowed | 4 ☐ Divorced | d | If Yes, (Year or | Give Dates: | 1970 | | 1 🗌 Yes | 2LA-No | Specity: | | | | Specify | v: WH | HITE |
| olical Exp | Completed | (Spe | 15. Deceder | | | d) | | 16a. Dece | dent's Usua kind of wo DO NOT us | al Occupa | ation during mos | t of work | ina | 16b | . Kind of Bu | usiness/l | ndustry |
| P W | du l | Elementary/Sec | | Ĭ | College | (1-4or 5+) | | | | | | | 3 | | TMDIIC | mn T 4 | т. |
| DT IN | | 17. Father's Name | (Einst Middle | (act) | 4 | | | TKU | CK DR | TAEK | | ada Nasa | - /Fina 14in | | INDUS | | \L |
| 0 0 0 | m | | N C. SH | | | | | | | | | | e (First, Mid RAIGN | | ien Suman | ne) | |
| | ၉ | 19a. Informant's N | | | oe, Print) | | | 19b. Maili | ng Address | s (Street a | | | al Route Nu | | ty or Town, | State, Z | ip Code) |
| er trau | 1 | PEGGY SH | ARP/WIF | FE | | | | | . BOX | | | | | 254 | | | |
| | | 20a. Method of Dis | * | a 🗆 🗆 | | 01-1- | 20b. Plac | ce of Dispendence | osition (Nar. matory or o | me of other place | 6) | [| Date | 20c | . Location - | City or T | Town, State |
| iry or | | | Cremation 5 Other (5 | | emovai froi | | | | CEME | - | | 10/14 | 4/2006 | PA | W PAW | , wv | 7 |
| any injury or | | 21. Signature of F | uneral Service | License | 0 | | | | 2. Name an | | | ty | KIMBL | E FU | NERAL | НОМ | Œ |
| E 8 | | | 74 ~ | ر کیا، | and | 1- | | 1 | 88 MO | SER | AVEN | JE I | PAW PA | | | 434 | |
| ician dical niner | | 23a. Part1. Enter shock, or he Immediate Cause disease or conditi resulting in death) | (FINAL ion) | r compiler tonly one | Due t | o (or as a | conseque | De not en di OV | | | | cardiac d | or respirator | y arre | isea | se | Approximat Interval Bet nse and ITO |
| dical niner | Examiner | disease or conditi | onditions, mmediate lerlying ts | a. b. | Due t | UD | conseque | nce of): | | | | cardiac | or respirator | e o | | se | Approximat Interval Bet Inser and I |
| for use as the burial-transit | Examiner | Immediate Cause disease or conditi resulting in death) Sequentially list of if any, leading to it cause. Enter Und Cause (Disease of that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 11. | (Final loon) onditions, mmediate lerlying rinjury is Last nt pregnant 2 months? | d. | Due to | o (or as a of o (or as a of o (or as a of o (or as a of o (or as a of o of o b birth 2 grant at tir | consequel consequel consequel | Do not en di OV | | de la dylinia de | | cardiac c | or respirator | y arre | | re of deliv | Interval Bet nse and |
| or we assert and transit and t | Physician/Medical Examiner | Immediate Cause disease or conditi resulting in death) Sequentially list or if any, leading to i cause. Enter Und Cause (Disease o that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 12 | (Final loon) onditions, mmediate lerlying r injury ts Last nt pregnant 2 months? | a. b. c. d. | Due to | o (or as a of o (or a)))))))))))))))))))))))))))))))))))) | consequer consequer pregnanc | Do not en di OV | ter the mod | regnancy | Hyp | 77 | ND | | isea 23d. Dat Mod | te of deliv | Interval Bet nsel and 11111111111111111111111111111111111 |
| dicac of the attended for use as the burial-transit be detached for use as the burial-transit | by Physician/Medical Examiner | Immediate Cause disease or conditi resulting in death) Sequentially list or if any, leading to i cause. Enter Und Cause (Disease o that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 1/2 1 Yes 2 9 Unknown | (Final loon) onditions, mmediate lerlying r injury ts Last nt pregnant 2 months? | a. b. c. d. | Due to | o (or as a of o (or a)))))))))))))))))))))))))))))))))))) | consequer consequer pregnanc | nnce of): nnce of): sy eath 35 [th 5 [| ter the mod | regnancy | Hyp | 77 | 23e. D | id tobacc | 23d. Date Mod | te of deliv | Interval Bet insel and ins |
| dicac of the attended for use as the burial-transit be detached for use as the burial-transit | by Physician/Medical Examiner | Immediate Cause disease or conditi resulting in death) Sequentially list or if any, leading to i cause. Enter Und Cause (Disease o that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 1/2 1 Yes 2 9 Unknown | (Final loon) onditions, mmediate lerlying r injury ts Last nt pregnant 2 months? | a. b. c. d. | Due to | o (or as a of o (or a)))))))))))))))))))))))))))))))))))) | consequer consequer pregnanc | nnce of): nnce of): sy eath 35 [th 5 [| ter the mod | regnancy | Hyp | 77 | 23e. D | id tobacc | 23d. Date Mod | te of delivinth iribute to 3 Pro | very Day the cause of couplings findings |
| gie 2 should be detached for use as the burial-transit | by Physician/Medical Examiner | Immediate Cause disease or conditi resulting in death) Sequentially list or if any, leading to i cause. Enter Und Cause (Disease o that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 1/2 1 Yes 2 9 Unknown | (Final loon) onditions, mmediate lerlying r injury ts Last nt pregnant 2 months? | a. b. c. d. | Due to | o (or as a of o (or a)))))))))))))))))))))))))))))))))))) | consequer consequer pregnanc | nnce of): nnce of): sy eath 35 [th 5 [| ter the mod | regnancy | Hyp | 77 | 23e. D 11 24a. W | did tobacc Yes as an utopsy driftormed | 23d. Dat Mor | te of delivinth 3 □ Pro Were autorior to α death? | very Day the cause of coupled by sompletion of co |
| oage 2 should be detached for use as the burial-transit | e Completed by Physician/Medical Examiner | Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that infitiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 12.1 yes 2.2 yes 12.2 yes 12.3 yes 12 | (Final loon) onditions, mmediate lerlying r injury is: Last Int pregnant 2 months? No n | a. b. c. d. 23 | Due to | o (or as a of o (or a)))))))))))))))))))))))))))))))))))) | consequer consequer pregnanc | nnce of): nnce of): sy eath 35 [th 5 [| ter the mod | regnancy | H yp | - T | 23e. D 11 24a. W at pt 1 | id tobacc Yes Yes Yes Yes Yes Yes Yes Y | 23d. Dat Mor | te of delivinth ribute to 3 Pro Were autorior to or | very Day the cause of couplings findings |
| director, page 2 should be detached for use as the burish-transit on progression of the contract of the contra | Be Completed by Physician/Medical Examiner | Immediate Cause disease or conditi resulting in death) Sequentially list of if any, leading to it cause. Enter Und Cause (Disease of that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 11. 1 | (Final loon) onditions, mmediate lerlying r injury is: Last Int pregnant 2 months? No n | a. b. c. d. 23 | Due to | o (or as a of o (or a)))))))))))))))))))))))))))))))))))) | consequer consequer pregnanc Fetal de me of deat | nnce of): nnce of): sy eath 35 [th 5 [| Ectopic pr | regnancy secity) | en in Part I | - T | 23e. D 11 24a. W au ps 1 Ye. | Yes an atopsy prormed s 220 world | 23d. Dat Moi | te of delivinth alignment of the control of the co | very Day the cause of cobably 4 opsy findings ompletion of c 2 \(\sum \text{No} \) |
| director, page 2 should be detached for use as the burish-transit on progression of the contract of the contra | To Be Completed by Physician/Medical Examiner | Immediate Cause disease or conditi resulting in death) Sequentially list of if any, leading to it cause. Enter Und Cause (Disease) IF FEMALE: 23b. Was deceded in the past 1/2 1 Yes 2 9 Unknown Part II. Other sign 25. Was case refe examiner? 1 Yes 2 27. Manner of Death | onditions, mmediate lerlying r injury is: Last Int pregnant 2 months? No n ifficant conditions wered to medical | a. b. c. d. 23 | Due to | o (or as a o o (or as a o o (or as a o o o (or as a o o o (or as a o o o o (or as a o o o o o o o o o o o o o o o o o | consequer consequer pregnanc Fetal de me of deal | Do not en Cd I OV Ince of): Ince of) | Ectopic production of the control of | regnancy sectify) | en in Part I | of Death | 23e. D 11 24a. W au ps 1 Ye. | Yes as an atopsy prormed s 220 wonel | 23d. Dat Moi | te of delivinth alignment of the state of t | very Day the cause of cobably 4 opsy findings ompletion of c 2 \(\sum \text{No} \) |
| director, page 2 should be detached for use as the burish-transit on progression of the contract of the contra | To Be Completed by Physician/Medical Examiner | Immediate Cause disease or conditi resulting in death) Sequentially list cirif any, leading to it cause. Enter Und Cause (Disease of that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 1/2 1 Yes 2 9 Unknow. Part II. Other sign. | onditions, mmediate lertying r injury is: Last Int pregnant 2 months? No n ifficant condition No the condition No the condition No the condition S Pendir investi | b. c. d. 23 ions cont | Due to | o (or as a of o (or a) (or as a of o (or a) (or as a of o (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) | consequer consequer pregnanc Fetal de me of deal | Do not en d O V | Ectopic production of the control of | regnancy pecify) Pause give | en in Part I | o of Death | 23e. D 11 24a. W au pe 1 | Yes as an atopsy prormed s 220 wonel | 23d. Dat Moi | te of delivinth alignment of the state of t | very Day the cause of cobably 4 opsy findings ompletion of c 2 \(\sum \text{No} \) |
| or the funeral director, page 2 should be detached for use as the burial-transit on programment of the funeral director, page 2 should be detached for use as the burial-transit on programment of the funeral director. | To Be Completed by Physician/Medical Examiner | Immediate Cause disease or conditi resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease ot that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 11. 1 Yes 2 9 Unknow. Part II. Other sign. | onditions, mmediate lerlying rinjury is: Last Int pregnant 2 months? No n ifficant condition ifficant condition No ath 5 Pendir investi 6 Could | a. b. c. d. 23 ions cont | Due to Du | o (or as a of o | consequent | Do not en CI I OV Ince of): nce of): nce of): nce of): results 3 [th 5 [R/Outpatier 8b. Time of Injury | Ectopic production of the state | regnancy secity) ause give | en in Part I | of Death | 23e. D 11 24a. W au pe 1 | Yes as an atops of a former of the control of the c | 23d. Dat Moi 24b. V F Rough of Course Control 2 No 1 1 6 Other Significant of Course C | te of delivinth 3 Pro Were autorior to codeath? Yes er (Special ed) | very Day the cause of cobably 4 opsy findings ompletion of c 2 \(\text{No} \) |
| or the funeral director, page 2 should be detached for use as the burial-transit on programment of the funeral director, page 2 should be detached for use as the burial-transit on programment of the funeral director. | Certification; To Be Completed by Physician/Medical Examiner | Immediate Cause disease or conditi resulting in death) Sequentially list of if any, leading to it cause. Enter Und Cause (Disease of that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 11. 1 Yes 2 9 Unknow. Part II. Other sign. 25. Was case referexaminer? 1 Yes 2 27. Manner of Death 2 4 4 2 4 4 2 4 4 4 | onditions, mmediate lerlying r injury is: Last Int pregnant 2 months? No n ifficant condition ifficant condition No ath 5 Pendia investi 6 Could determ | a. b. c. d. 23 ions cont | Due to Du | o (or as a o o (or as a o o (or as a o o o (or as a o o o (or as a o o o o o o o o o o o o o o o o o | pregnanc pregnanc Fetal de me of deal not resulti (ear) 2 EF | Do not en CI I O V | Ectopic pr Other (sp Int 3 Do Int 2 M reet, factory | regnancy pecify) DA Other PSe: Injury Work 1 \(\) y, office | 26. Place 26. Place 27. 4 \(\text{Nu} \) 28. ves 2 \(\text{Place} \) | o of Death | 23e. D 11 24a. W at pe 1 Peck on me 28d. Descrit | Yes as an anotopsy difference on the wire one of the wire of the | 23d. Dat Mod So use control 2 No 24b. V Control 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 | te of deliverable to of delive | very Day the cause of clubably 4 opsy findings ompletion of c 2 \(\text{No} \) No |
| or the funeral director, page 2 should be detached for use as the burial-transit on programment of the funeral director, page 2 should be detached for use as the burial-transit on programment of the funeral director. | Certification; To Be Completed by Physician/Medical Examiner | Immediate Cause disease or conditi resulting in death) Sequentially list or disease. Enter Und Cause. Enter Und Cause (Disease that initiated even resulting in death) IF FEMALE: 23b. Was deceded in the past 12 1 2 9 Unknow. Part II. Other sign. 25. Was case refe examiner? 1 2 Yes 2 27. Manner of Death and Individual 12 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) | onditions, mmediate letiying r injury is: Last Int pregnant 2 months? No n ifficant conditi verred to medica No the Could determ 1 Certifyin | a. b. c. d. 23 ions cont | Due to Du | o (or as a o o (or as a o o (or as a o o o (or as a o o o (or as a o o o o (or as a o o o o o o o o o o o o o o o o o | consequent | Do not en Cd 1 O V Ince of): nce of): nce of): read in the u R/Outpatier 8b. Time o Injury e, farm, str | Ectopic production of the state | regnancy pecify) ause give | en in Part I 26. Place 27. 4 Nu at 7. /es 2 date an | of Death | 23e. Di 24a. W au au 1 | Yes as an atopsy afformed s one how in (Street | 23d. Date Moi So use control 2 No 24b. V 5 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C | te of delivinth sibute to Tr | very Day the cause of completion of complet |
| or the funeral director, page 2 should be detached for use as the burial-transit on programment of the funeral director, page 2 should be detached for use as the burial-transit on programment of the funeral director. | ledical Certification; To Be Completed by Physician/Medical Examiner | Immediate Cause disease or conditi resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease ot that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 12 1 Yes 2 9 Unknow. Part II. Other sign. 25. Was case reference warminer? 1 Yes 2 27. Manner of Death Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifler (Check only one) | onditions, mmediate leftying r injury is: Last Int pregnant 2 months? No n ificant conditi Vo atth 5 Pendir investi 6 Could determ 1 Certifying 2 Medical | a. b. c. d. 23 ions cont | Due to Du | o (or as a o o (or as a o o (or as a o o o (or as a o o o (or as a o o o o (or as a o o o o o o o o o o o o o o o o o | consequent | Do not en Cd 1 O V Ince of): nce of): nce of): read in the u R/Outpatier 8b. Time o Injury e, farm, str | Ectopic production of the state of the modern of the state of the stat | regnancy recity) ause give 28c. Injury Work 1 1 7 y, office at the tim, in my op | 26. Place or: 4 \(\text{Nu}\) at .? (es. 2 \(\text{Dirition, deal}\) | of Death | 23e. Di 24a. W au au 1 | yes as an atopsy of comments of the cause in | 23d. Date Moi 24b. V Fr. No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | te of delivinth ribute to 3 Pro Were autorior to coleath? Yes er (Special Yes) er or Rur anner as sand due to | very Day the cause of control of |
| pletely filled in by the funeral director, page 2 should be detached for use as the burial-transit or policy. | ledical Certification; To Be Completed by Physician/Medical Examiner | Immediate Cause disease or conditi resulting in death) Sequentially list of if any, leading to it cause. Enter Und Cause (Disease of that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 11. 1 Yes 2 9 Unknown Part II. Other sign. 25. Was case reference warminer? 1 Yes 2 27. Manner of Death 28. Manner of Death 29. Manner o | onditions, mmediate leftying r injury is: Last Int pregnant 2 months? No n ifficant conditi verred to medica No the Could determ 1 Certifyin | a. b. c. d. 23 ions cont | Due to Du | o (or as a of o o (or as a of o o (or as a of o o (or as a of o o (or as a of o o (or as a of o o o (or as a of o o o o o o o o o o o o o o o o o | consequent | Do not en Cd 1 O V Ince of): nce of): nce of): read in the u R/Outpatier 8b. Time o Injury e, farm, str | Ectopic production of the state of the modern of the state of the stat | regnancy pecify) ause give | 26. Place or: 4 \(\text{Nu}\) at .? (es. 2 \(\text{pinion}, \text{dea} \) | of Death | 23e. D 24a. W au pe 1 | yes as an atopsy of comments of the cause in | 23d. Date Moi 24b. V Fr. No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | te of delivinth ribute to 3 Pro Were autorior to coleath? Yes er (Special Yes) er or Rur anner as sand due to | very Day the cause of completion of complet |
| or the funeral director, page 2 should be detached for use as the burial-transit on programment of the funeral director, page 2 should be detached for use as the burial-transit on programment of the funeral director. | ledical Certification; To Be Completed by Physician/Medical Examiner | Immediate Cause disease or conditi resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease ot that initiated event resulting in death) IF FEMALE: 23b. Was deceded in the past 12 1 Yes 2 9 Unknow. Part II. Other sign. 25. Was case reference warminer? 1 Yes 2 27. Manner of Death Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifler (Check only one) | onditions, mmediate leftying r injury is: Last Int pregnant 2 months? No n ificant conditi Vo atth 5 Pendir investi 6 Could determ 1 Certifying 2 Medical | a. b. c. d. 23 ions cont | Due to Du | o (or as a of o of or as a of o of or as a of o of or as a of o of or as a of o of or as a of o of or as a of o of or as a of o of or as a of o of or as a of o of or as a of o of or as a of o of or as a of o of or as a of o of or as a of or o of or as a of or o of or as a of or o of or as a of or o or o of or o or o of or o or o | pregnanc pregnanc Fetal de me of deal not resulti At homic Specify) my knowle kamination d. | Do not en Cd 1 O V Ince of): nce of): nce of): read in the u R/Outpatier 8b. Time o Injury e, farm, str | Ectopic production of the state of the modern of the state of the stat | regnancy recity) ause give 28c. Injury Work 1 1 7 y, office at the tim, in my op | 26. Place or: 4 \(\text{Nu}\) at .? (es. 2 \(\text{pinion}, \text{dea} \) | of Death | 23e. D 24a. W au pe 1 | yes as an atopsy of comments of the cause in | 23d. Date Moi 24b. V Fr. No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | te of delivinth ribute to 3 Pro Were autorior to coleath? Yes er (Special Yes) er or Rur anner as sand due to | very Day the cause of control of |

DHMH 17 Rev 1/2001

Registrar

| ris. | | _ For | e Type or Prin | aryland / | Depa | ırtment | of He | ealth a | | | | _ | 37991 |
|--|-------------------|--|---|---|-------------------|------------------------------|---------------------|---------------------------|-----------------|-----------------------------------|----------------------|-------------------------------------|---|
| | | 1 State RegistraMFND# 23a(I+ 1. Decedent's Name (First, Middle, L | II),23bperMD1 | 1/8/06,BV | WIN | titicate | Of L | eatn | | 2. Date of De | Reg. N | 6.000 | 3. Time of Death |
| Physicia | | | LM JULIAN TAR | LTON | | | | | | Month NOVEMBER | D | ay Year 2006 | |
| /Medic Examin | | 4a. Facility Name (If not institution, g | | 22011 | | 4b. City, To | wn, or | Location of | of Death | TOTELDE | <u> </u> | c. County of De | |
| ZX | • | ATLANTIC GENERA | L HOSPITAL | | | | BER | LIN | | | | WORCEST | ER |
| Funeral | | Social Security Number 6. | Sex 7. Ag | e (In yrs. last bi | ,, | If Under 1 | Year Days | If Under | 24 Hrs. Min. | 8. Date of Bir (Month, Da | | 9. Bi | rthplace (State or Foreign |
| Director | | 238-18-4321 | IZIM ZLIF | 88 | Yrs. | | , | | | MARCH O | | | TH CAROLINA |
| land ow | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Tov | vn or Lo | cation | | | | | | | 10d. Inside City Limits |
| Marylan -f show fied at | tor | DELAWARE SUSSEX | | | S | ELBYVIL | LE. | | | | | | 1 ☐ Yes 2 No |
| with the Maryla t or 28e-f show | Director | 10e. Street and Number | | | | 10f. Zip C | | | | | 10g. C | itizen of What C | ountry? |
| | | 204 WEST STONEY | RUN | | | | | 19975 | 5 | | | U.S.A | • |
| ter dea | Funeral | 11. Marital Status | 12. Was Decedent Armed Forces? | | 13. V | Vas Deceder Yes, specify | t of His Cuban | panic Original | gin? (Spe | ecify Yes or No Rican, etc.) | 0" | 14. Race - Am Black, Wh | |
| s aft | by Fi | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give | _{No} 1941 - 1945 | . 1 | □Yes 2X |] No | Specify: | | | | Specify: W | HITE |
| 72 hour "natural" | | 15. Decedent's | Education | | . Deced | ent's Usual (| Occupat | tion | | | 16b. I | Kind of Busines | |
| I within 72 iene. r then "na | ple | (Specify only highest g Elementary/Secondary (0-12) | rade completed) College (1-4or 5 | 5+) | (Give I | kind of work OO NOT use | done di retired) | uring most | t of worki | n <i>g</i> | | | , |
| ad withir /giene. er then | Completed | 12 | | ., | EN | GINEER | | | | | | NASA | |
| be file stal Hy od oth even | Be | 17. Father's Name (First, Middle, Las | st) | | | | | 18. Mothe | r's Name | (First, Middle | , Maide | n <i>Sumam</i> e) | |
| d Mer narke | 2 | JESSE TARLTON | (Time Brief) | 100 | A A = 10 = | - Add /6 | | | | HOWELL | 0" | T | 7:0-13 |
| d 2 st th and th sr 7 ts r traur | | 19a. Informant's Name/Relationship ELAINE K. TARLTON - | | 1 | | | | | | | | or Town, State, | |
| ges 1 and 2 should be filed within to theatth and Mental Hygiene. If filem 27 is marked other then or other traumatic event, trains | | 20a. Method of Disposition | DAUGHTER | 20b. Place of | of Dispos | sition (Name | of | 1 | | ate | | AND 20912 Location - City o | |
| Pages nent of int: If it | | 1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec | | MARYLA | ND S' | | r piace | | 11/6/ | 2006 | CDO | UNCUTTIE | MADVI AND |
| permit. Pages Department of t Important: If ite any injury or of | | 21. Signature of Funeral Service Lic | | VETERA | 22 | EMETERY Name and | Address | of Facilit | у | | | WIND VILLE, | MARYLAND |
| Dageaa | | Myelin T. | Meen | | 1. | INES-RII 1800 NEV | VALDI V HAN | L FUNE MPSHIR | KAL H E AVE | OME, INC | VER . | SPRING, M | ARYLAND 20904 |
| Physician /Medical Examiner | | 23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) | ty one cause on each li | the death. Do | rova | er the mode of SCular | of dying | , such as cider | cardiac o | r respiratory a | rrest, | | Approximate Interval Between Onset and Death |
| ate be executed hysician and the burial-transit | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | a consequence | | | | | | | | | |
| The law requires that the death certificate be to the has been signed by the attending physician bage 2 should be detached for use as the buri | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 Fetal death | | Ectopic preg Other (speci | | | | | | 23d. Date of de Month | alivery Day Year |
| w requires that been signed should be det | leted by P | Part II. Other significant conditions A Cib At: | contributing to death b | - | in the un | derlying cau | se giver | n in Part I. | | 23e. Did t | | \ / | to the cause of death? Probably 4 Unknown |
| law requas been 2 shoul | plet | Chr | ronic Obstr | ructive | Pulr | nonary | Dis | sease | 2 | 24a. Was | | 24b. Were a | utopsy findings available completion of cause of |
| | Compl | CHE CO | ngestive He | art Fai | lure | ∋ | | | | perfo | rmed? | death? o 1 ☐ Ye | V |
| ysician: Th | Be (| 25. Was case referred to medical examiner? | | | | | | | of Death | (Check only o | on <i>e)</i> | | |
| Physi this c | <u>L</u> | 1 Yes 2 No | Hospital: | | - | | Other | 4 🗀 140 | | | | 6 ☐Other (Spe | ecify) |
| ding h. After funer | tlon | 27. Manner of Death Natural 5 Pending Accident Investigati | 28a. Date of Inju (Month, Da | y Year) | Time of Injury | M 280 | Injury Work1 | at ? es 2∐1 | | 28d. Describe | now inju | ary occurred | |
| for Attending Physician: after death. Director: After this certific I in by the funeral director, | Certification; | 2 Accident Investigation 3 Suicide 6 Could not determine | be ass place of ini | ury - At home, fa c. (Specify) | arm, stre | | | | | 28f. Location (City or To | Street a wn, Stat | nd Number or F e) | Bural Route Number, |
| To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this or Completely filled in by the funeral director. | edical C | 29a. Certifier Certifying I (Check only one) | Physician: To the best aminer: On the basis o and manner st | f examination ar | e, death | occurred at estigation, in | the time my opi | e, date and nion, deat | d place, a | and due to the ed at the time, | cause(s | s) and manner a id place, and du | s stated. e to the cause(s) |
| To th withir To th comp | Me | 29b. Signature and title of certifier | | | | 29c. L | icense | number | | | 29d. Da | ate signed (Mon | th. Day, Year) |
| nx14 | | Ison I | Symula 1 | 00 | | _ 1 | 60 | 644 | 28 | | Ī | 1/1/20 | 06 |
| 70 | | // | Postpleted cause of d | | | | | | | | | A Company | |
| Sta | to | 31. Date filed (Month, Day, Year) | zymala DO 32. sigistr | At Los tos ar's Signature | ten | rollton | 2.401 | 473 |) Iteal | Hung Mrc | Berl | mMD2 | 1811 |
| Registr | - 8 | NOV 08 | 2006 | is the | 15 | BALL! | | | | | | | |

| | | | 1 - For State Registrar | State of Mary | land / Depa | | Health and | | _ | 37992 |
|-------------------|--|---------------------|---|--|---------------------------------------|--|---|---|--|--|
| | Physici | an | 1. Decedent's Name (First, Middle, Las | • | h 1 | | | 2. Date of Dear Month | er 14, 20 | 3. Time of Death |
| | /Medic | al | 4a. Facility Name (If not institution, give | Arthur Two | ыпоту | 4b. City, Town | , or Location of Dea | | 4c. County of Dea | |
| 30 | Lxamii | ्री | 14119 Zinnia L | ane | | | stown | | Washin | gton |
|) (A) | Funeral Director | | 5. Social Security Number 6. Se 068-26-6127 Usual Residence of Decedent | With a DE | yrs. last birthday) 72 Yrs. | If Under 1 Yea Months Day | r If Under 24 Hr s Hours Mir | n. (Month, Day, | 9. Bii 0 , 1933 Eri | rthplace (State or Foreign ountry) e, PA |
| | yland | | 10a. State 10b. County | 100 | c. City, Town or Lo | ocation | | , | | 10d. Inside City Limits |
| | e Mar | ctor | MD Washingt | on I | lagersto | vn | | | | 1 ☐ Yes 2 XNo |
| | with th | Dire | 10e. Street and Number | | | 10f. Zip Code | | 1 | 0g. Citizen of What C | ountry? |
| | heath ne 23 | eral | 14119 Zinnia Lane | 12. Was Decedent Ever | in U.S. 13. | 2174 Was Decedent o | | Specify Yes or No- | USA 14. Race - Am | erican Indian, |
| 036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Enam that must be notified at ance. | by Funeral Director | 1 □ Never Married 2 □ Marned 3 ★ Widowed 4 □ Divorced | Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: | | If Yes, specify Cu 1 ☐ Yes 2 ☑ N | | Specify Yes or No- irto Rican, etc.) | Black, Whi | |
| 21215-0036 | 72 ho | Completed | 15. Decedent's Edi (Specify only highest grad | ucation de completed) | (Give | dent's Usual Occ kind of work dor | e during most of w | orking | 16b. Kind of Business | /Industry |
| 121 | within ene. than | dmo | Elementary/Secondary (0-12) | College (1-4or 5+) +2 | | DO NOT use reti | | | Managama | |
| <u>م</u> | be filed htal Hygid od other event, I | BeC | 17. Father's Name (First, Middle, Last) | <u> + 2</u> | bus. | iness Ow | | ame (First, Middle, I | Nursery Maiden Sumame) | |
| Maryland | Menta | To | Arthur Steven T | | | | Gladys | | Harf | |
| Mar | d 2 sh th and th and 17 is m | | 19a. Informant's Name/Relationship (T | | | 17 55 | | | City or Town, State, | Zip Code) |
| altimore, | Pages 1 and 2 nent of Health ont: If item 27 ary or other tru | | Amy Mittelman / Da 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ 4 □ Donation 5 □ Other (Specify, | Removal from State | Ob. Place of Dispo cemetery, cre | matory or other p | lace) | | 20c. Location - City or | |
| Ħ | nit. Parametranten ortent injury | | 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Furreyal Service Licens | | mithsburg | Crematorion of the Crematorion o | | | Smithsburg | , MD ineral Home |
| ä | Depa Impo any is | | Van-7 | 7 | | | (| | wn, MD 21 | |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of | lications that caused the ne cause on each line. | death. Do not en | ter the mode of d | ying, such as cardi | ac or respiratory arri | est, | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a. Cardia | | ry then | nea | | | Immediat |
| | Examiner | | | Due to (or as a con | Δ | - Ten | Disea | 54 | | |
| | D # | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a cor | rsequence of): | | | · Rise | | |
| | ate be executed hysicien and the burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. HYULLO Due to (or as a cor | | gter l | asula | 1 Hise | ace ' | |
| 760, | e be e. sicien e buria | cal E | l | d | | | | | | |
| 89 | ntificate ng phy as the | | IE SCHALE. | G | | | | | | |
| Вох | death certifica attending pt I for use as t | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pr | Fetal death 3 | Ectopic pregnar | псу | | 23d. Date of de | livery Day Year |
| o. | the de | yslc | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4 Pregnant at time 9 Unknown | ordeath 5t | Other (specify) | | | | , |
| Records, P. | Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit | þ | Part II. Other significant conditions co | P | t resulting in the u | nderlying cause | given in Part I. | | pacco use contribute t | o the cause of death? |
| 000 | ie law rec has bee ge 2 shot | Completed | | | | | | 24a. Was a autops | n 24b. Were a | utopsy findings available completion of cause of |
| <u> </u> | : The cate h | Соп | | | | | | perform | ned? death? | 2 □ No |
| <u> </u> | sician: Th certificate irector, pag | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | 2 ER/Outpatier | | 26. Place of Dither: 4 🗆 Nursing | eath (Check only on | | |
| o | ding Phys 7. After this funeral di | n: To | 27. Manner of Ceath | 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea | 28b. Time o | f 28c. In | | | nce 6 Other (Spe w injury occurred | эслу) |
| Sior | Attending ir death. ector: After by the fune | catlo | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | and and a | | ☐Yes 2☐No | | | |
| Division of Vital | or afte Dir | Certification: | 4 Homicide determined | 28e. Place of Injury - building, etc. (S _i | At home, farm, str pecify) | eet, factory, offic | 8 | 28f. Location (St City or Town | reet and Number or R i, State) | ural Route Number, |
| | To the Hospital or within 24 hours after To the Funerel Dir completely filled in | ledical | 29a. Certifier Check only one) | rsician: To the best of my iner: On the basis of exa- and manner stated. | knowledge, deat mination and/or in | h occurred at the vestigation, in my | time, date and place opinion, death occ | ce, and due to the ca curred at the time, da | use(s) and manner a ate and place, and du | s stated. e to the cause(s) |
| | To the within 2 To the Complete | Med | 29b. Signature and title of certifier | discondining stated. | | 29c. Lice | nse number | 2 | 9d. Date signed (Mon. | th, Day, Year) |
|) | | | ► May E U | lowy b! | | DZ | 23815 | | 11/15/ | 6 |
| \AJ | 4-20+1 | | 30. Name and address of person who c | ompleted callse of death | (Item 23a) (Type, | Print) / | st. Ha | coisto | un . mi | 221740 |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32. Aggistrar's S | Signature | a- | 7, 7, 0 | 7 | | |
| | Registr | | NOV 16 20 |)06 Jan | B. A. | arte | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Janet Marie Townsend 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hiconico Pennsua Regional SA/ISBIKU Medica 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 11/9/1947 9. Birthplace (State or Foreign Country) Delaware **Funeral** 1 □ M 2 🕇 F 222-30-2880 59 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shov must be notified at 1 XYes 2 No Director Maryland Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8668 Poole Street 21875 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, r than "natural", or items the Medical Examiner m 11. Marital Status Black, White, etc. 1 Never Married 2 Married anet 1 ☐ Yes 2X No Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Hotel Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin Edward Joseph Jr. Kathryn Frances Tapman ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i Barbara A. Nelson/sister 8668 Poole St., Delmar, MD 21875 injury or other Baltimore, 20b. Place of Disposition (Name of Date 20a, Method of Disposition 20c. Location - City or Town, State Pages 1 Springhilling Memory Burial 2 ☐ Cremation 3 ☐ Removal from State 11/18/06 4 □ Donation 5 □ Other (Specify) Gardens Hebron, MD ²², Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Signature of Funeral Service Licensee CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATTE LUNG disease or condition resulting in death) MINON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ed by the se 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 1No To the Hospitai or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 76 Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Beath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Datural 5 Pending 2 Accident M 1 ∏Yes 2 ∏No investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homiçide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M 0006 2416 NOVEMBER 12, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 SCUPE 010-51000 SEIN 3 SMICHURY # 3180 1122 mm GUT/GRAGEZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Blow H Sparts DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 🖟 🎧 🦒 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** WOT 2006 36RM Ma NOV 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY 13803 CONGRESS DR ROCKVILLE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛱 F 90 212 7599 21 Director SEPT.31,1916 KOREA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumatic event, I've Madical Examination ust be mailthed at 1 XYes 2 No Be Completed by Funeral Director MONTGOMERY ROCKVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 13803 CONGRESS DR. KOREA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Yes 2 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced ASIAN Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be finent of Health and Mental I soft: If item 27 is marked or SUNG MOON TAI KAN NAN KIM ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DUK 13803 CONGRESS DR ROCKVILLE MD 20853 WOO SON Η 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3 ☐Removal from State 1 Burial 2 □ Cremation 3 [
'4 □ Donation 5 □ Other (Speci ō Department of Importent: If any injury or NORBECK MEMORIAL 11/17/06 OLNEY MD 22. Name and Address of Facility CHARLES HINDS FUNERAL SERVICE 21. Signature of Fineral Service 20772 12303 KAYAK DR UPPER MARLBORO MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician NEGIY disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Unknown 1 Yes 20 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 1 Yes 2 🗌 No 1 Yes Hospital or Attending Physicien: 25. Was case referred to examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Cther: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe MD W neleted cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Dav. Year)

NOV

1 6 2006

MID

32. Registrar's Signature

| | | 1 | For State Registrar | State 0 | r Maryland | | irtment of H tificate of I | | | Reg. No.2 0 0 6 | 37995 |
|---------------------------------------|--|---|---|---|--|---|--|---|--|--|---|
| | | | Decedent's Name (First, Middle, Last | it) | | | | | 2. Date of Dea | | 3. Time of Death |
| | Physicia | _ | Charles Albert W | ΛΨΥΤΝΟ | | | | | Nov. | Day Year 14 2006 | 12:10 P M |
| | /Medic | | 4a. Fecility Name (If not institution, give | | nber) | | 4b. City, Town, or | Location of Death | NOV | 4c. County of Dea | |
| | Examin | er | Avalon Manor Nur | | | | Hagers | etown | | Washingto | nn . |
| | | | 5. Social Security Number 6. S | | 7. Age (In yrs. I | ast birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birt | h 9 Bir | thplace (State or Foreign |
| | Funeral Director | | | MM 2□F | 89 | Yrs. | Months Days | Hours Min. | (Month, Da | 6 1917 New | ountry) York City |
| | | - | Usual Residence of Decedent | | | | | | 100. 2 | <u> </u> | |
| 200 | land ow | | 10a. State 10b. County | | 10c. City | , Town or Lo | cation | | | | 10d. Inside City Limits |
| 9 | Mary | ğ | Maryland Washing | ton | н | agerst | own | | | | 1X Yes 2 No |
| 4 | 288 | Director | 10e. Street and Number | COII | | agers c | 10f. Zip Code | | | 10g. Citizen of What C | ountry? |
| 4 | with so or | | 100 E T | | | | 21 | 742 | | USA | |
| 4 | hours atter death with the Maryland turet', or Items 23a or 28a-f show al Evaninar must be mutitod at | Funeral | 120 E. Irvin Aven | | edent Ever in U. | S. 13. V | | ispanic Origin? (Spe In, Mexican, Puerto | cify Yes or No | | |
| 1 | Hen her | 5 | 1 ☐ Never Married 2X Married | Armed Fo | rces? | | | | Rican, etc.) | Black, Whi | te, etc. |
| 9 | rs aff | by | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Gir Year or D | /e | 1 | I∐Yes 2∭QNo | Specify: | | Specify: W | nite |
| 9500-6121 | hou ture | | 15. Decedent's Ed | | | 16a. Deced | ient's Usual Occup | ation | | 16b. Kind of Business | s/Industry |
| က် ကြ | "nat | Completed | (Specify only highest gra | | | (Give life. L | kind of work done of DO NOT use retired | during most of worki | ng | Blast Cle | eaning |
| | with ene. | Ē | Elementary/Secondary (0-12) | College (| 1-40r 5+) | Mecha | nical En | gineer | | Manufactur | ing |
| ם ס | be filed within 72 hours after death with the Marylan be filed with Hygiene. d other then "naturel", or flems 23a or 28a-f show event, it a Medical Examination into the modified at | | 17. Father's Name (First, Middle, Last) | | | | | | (First, Middle, | Maiden Surname) | |
| a a | d be antal | o Be | Daniel A. Watkins | | | | | Flora Sa | villa G | assman | ! |
| = [| should be nd Mental marked o | ဥ | 19a. Informant's Name/Relationship (| | | 19b. Mailin | ng Address (Street | | | ar, City or Town, State, | Zip Code) |
| <u> </u> | d 2 s th an 17 is trau | | | | | RD 1 | Boy 18 | 5B Proct | or Wes | t Va. 2605 | 5 |
| ď, | 1 an Heali em 2 ther | 1 | Daniel B. Watkins 20a. Method of Disposition | - 5011 | 20b. P | lace of Dispo | sition (Name of | | Date | 20c. Location - City or | |
| ō | Pages nent of I ant: If it ury or o | | 1 ☐ Burial 2 K Cremation 3 ☐ | | State | | natory`or other plac | | (100 | II | Marriland |
| Baltimore, Maryland 2 | permit. Pages 1 and 2 should be li Department of Healin and Mental H Importent: If item 27 is marked oil any injury or other traumatic even once. | | `4 □Donation 5 □Other (Specif | | Hag | | 4- | ory 11/1 | | Hagerstown | |
| 39 | epar epar npor ny in | | 21. Signature of Funeral Service Licer |) 1. | | | | | | uneral Home | |
| | ă,O ⊆ m ol | | Bolint St | uhu | | | | | | stown, Md. | Approximate |
| | | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that one cause on | aused the death each line. | n. Do not ent | er the mode of dyir | ng, such as cardiac o | or respiratory a | rest, | Interval Between Onset and Death |
| | hysician | 0.3 | Immediate Cause (Final disease or condition | 2 | | Sepr | ~ | | | | pero den |
| | /Medical | | resulting in death) | Due to | (or as a consequ | uence of): | | | | | |
| | Examiner | | Sequentially list conditions, | b | | | rimania | | | | 1-h wuty |
| | | ner | ri any, leading to immediate cause. Enter Underlying | Due to | (or as a consequ | uence of): | | | | | |
| | cuted | Examiner | that initiated events | c | | | | | | | |
| oʻ | icate be executed physician and s the burial-transit | Ä | resulting in death) Last | Due to | (or as a conseq | uence of): | | | | | |
| 8760 | te be ysici | dlcai | | đ | | | | | | | |
| | tifica ng ph as th | 77 | | _ u | | | | | | | |
| 68 | ± .≒ o | ě | 15 55 111 5 | | | | | | | | |
| ox 68 | hoe bud | an/Med | IF FEMALE: 23b. Was decedent pregnant | | tcome of pregna | | Ectopic pregnancy | , | | 23d. Date of de | |
| . Box 68 | death ce e attend od for us | ician/Med | | 1∏Live 4∏Preg | oirth 2 ☐ Feta nant at time of d | Ideath 3□ | Ectopic pregnancy | ′ | | 23d. Date of de Month | alivery Day Year |
| .O. Box 68 | I the death ce by the attend ached for us | hysician/Med | 23b. Was decedent pregnant in the past 12 months? | 1□Live | oirth 2 ☐ Feta nant at time of d | Ideath 3□ | | , | | Month | Day Year |
| s, P.O. Box 68 | s that the death certifined by the attending e detached for use as | y Physician/Med | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No | 1□Live 4□Preg 9□Unkr | oirth 2 ☐ Feta nant at time of d nown | Ideath 3[eath 5[| Other (specify) | | | Month obacco use contribute | Day Year to the cause of death? |
| s, P.O. Box 6 | quires that the death ce in signed by the attend uld be detached for us | ed by Physician/Med | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 1□Live 4□Preg 9□Unkr | oirth 2 ☐ Feta nant at time of d nown | Ideath 3[eath 5[| Other (specify) | | | Month obacco use contribute | Day Year |
| s, P.O. Box 6 | w requires that the death ce s been signed by the atlend s should be detached for us | leted by Physician/Med | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions | 1□Live 4□Preg 9□Unkr | oirth 2 ☐ Feta nant at time of d nown | Ideath 3[eath 5[| Other (specify) | | 1 ☐ 1 | obacco use contribute Yes 2 No 3 F | to the cause of death? Probably 4 Linknown |
| s, P.O. Box 6 | he law requires that the death ce e has been signed by the attend ige 2 should be detached for us | ompleted by Physician/Med | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions | 1□Live 4□Preg 9□Unkr | oirth 2 ☐ Feta nant at time of d nown | Ideath 3[eath 5[| Other (specify) | | 1 24a. Was | Month obacco use contribute Yes 2 No 3 F an 24b. Were a prior to death? | Day Year to the cause of death? Probably 4 Dunknown autopsy findings available completion of cause of |
| s, P.O. Box 6 | The law requires that the death ce firate has been signed by the attend or, page 2 should be detached for us. | Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the part 12 No 12 | 1□Live 4□Preg 9□Unkr | oirth 2 ☐ Feta nant at time of d nown | Ideath 3[eath 5[| Other (specify) | ven in Part I. | 24a. Was auto perio 1 Yes | Month obacco use contribute Yes 2 \ No 3 \ F an 24b. Were a prior to death? 2 \ Abe 1 \ Ye | to the cause of death? Probably 4 Linknown autopsy findings available ocompletion of cause of |
| s, P.O. Box 6 | sicien: The law requires that the death ce certificate has been signed by the attend irector, page 2 should be detached for us. | Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 25. Was case referred to medical examiner? | 1 Live 4 Preg 9 Unkr | inth 2 Feta nant at time of d own leath but not res | I death 3 [eath 5 [| Other (specify) | ren in Part I. | 1 24a. Was auto perfo | Month obacco use contribute Yes 2 No 3 F an 24b. Were a prior to death? 2 Ne 1 Ye | Day Year to the cause of death? Probably 4 DUnknown autopsy findings available completion of cause of |
| of Vital Records, P.O. Box 6 | v requires been sign should be | To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months and 12 months are significant conditions of the past 12 months are significant conditions of the past 12 months are significant conditions of the past 12 months are significant conditions of the past 12 months are significant conditions of the past 12 months are significant conditions of the past 12 months are significant conditions of the past 12 months are significant conditions of the past 12 months are significant conditions of the past 12 months? | Hospital: | Inpatient 2 Feta | I death 3 [eath 5 [| Other (specify) | 26. Place of Deat | 24a. Was autoperformer 5 Resi | Month obacco use contribute Yes 2 \ No 3 \ F an 24b. Were a prior to death? 2 \ Abe 1 \ Ye | Day Year to the cause of death? Probably 4 DUnknown autopsy findings available completion of cause of |
| of Vital Records, P.O. Box 6 | ding After fune | To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 | Hospital: 1 28a. Date | Inpatient 2 Feta | I death 3 Each 5 E | Other (specify) | 26. Place of Deat | 24a. Was autoperformer 5 Resi | Month obacco use contribute of the contribute o | Day Year to the cause of death? Probably 4 DUnknown autopsy findings available completion of cause of |
| of Vital Records, P.O. Box 6 | ding After fune | To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 | Hospital: 1 28a. Date (Mo) | Inpatient 2 Inpaty | I death 3 Each 5 ER/Outpatier 28b. Time o Injury | Other (specify) Inderlying cause given the second | 26. Place of Deather: 4 Nursing Hoyat | 24a. Was autopento | Month obacco use contribute of Month Yes 2 No 3 Famous Prior to death? 2 Above 1 Yes one) dence 6 Other (Sp. how injury occurred | Day Year to the cause of death? Probably 4 Dunknown autopsy findings available completion of cause of is 2 No |
| vision of Vital Records, P.O. Box 6 | ding After fune | To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 | Hospital: 1 | Inpatient 2 Inpaty | eath 5 Endouble of the ulting in the ulting in the ulting in the ultime of the ultime | Other (specify) | 26. Place of Deather: 4 Nursing Hory at the? | 24a. Was autopende per per per per per per per per per pe | Month obacco use contribute of Month Yes 2 No 3 Famous Prior to death? 2 Above 1 Yes one) dence 6 Other (Sp. how injury occurred | Day Year to the cause of death? Probably 4 Dunknown autopsy findings available completion of cause of is 2 No |
| vision of Vital Records, P.O. Box 6 | ding After fune | Certification: To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 | Hospital: 1 28a. Date (Mo) | Inpatient 2 Injury - At hing, etc. (Specification) | Ulting in the u ER/Outpatier 28b. Time o Injury ome, farm, str | ndertying cause given to a simple cause given to a sim | 26. Place of Deather: 4 Nursing Hory at k? Yes 2 No | 24a. Was auto perfect of the control | Month obacco use contribute to Yes 2 No 3 Famous Primed? an 24b. Were a prior to death? 1 Yes 2 No 1 Yes Primed? an 24b. Were a prior to death? 1 Yes Primed? dence 6 Other (Sp how injury occurred) Street and Number or Famous Prime, State) | Day Year to the cause of death? Probably 4 |
| Division of Vital Records, P.O. Box 6 | Hospitel or Attending 4 hours after death. Funerel Director: After ely filled in by the fune | Certification: To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 | Hospital: 1 28a. Date (Mo.) 28b. Plac build hysicien: To the miner: On the | Inpatient 2 Injury - At hing, etc. (Specification) | Ulting in the u ER/Outpatier 28b. Time o Injury ome, farm, str | ndertying cause given to a simple cause given to a sim | 26. Place of Deather: 4 Nursing Hory at k? Yes 2 No | 24a. Was auto perfect of the control | Month obacco use contribute of Month Yes 2 No 3 Famous Prior to death? 2 Above 1 Yes one) dence 6 Other (Sp. how injury occurred | Day Year to the cause of death? Probably 4 |
| Division of Vital Records, P.O. Box 6 | Hospitel or Attending 4 hours after death. Funerel Director: After ely filled in by the fune | To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 | Hospital: 1 28a. Date (Mo.) 28b. Plac build hysicien: To the miner: On the | Inpatient 2 of Injury - At heing, etc. (Specific ed best of my knopasis of examina | Ulting in the u ER/Outpatier 28b. Time o Injury ome, farm, str | ndertying cause given to a simple cause given to a sim | 26. Place of Deather: 4 Nursing Hory at tk? Yes 2 No | 24a. Was auto perfc 1 Yes h (Check only of the Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on C | Month obacco use contribute of the contribute o | Day Year to the cause of death? Probably 4 Linknown autopsy findings available of completion of cause of secify) Bural Route Number, as stated. se to the cause(s) |
| Division of Vital Records, P.O. Box 6 | or Attending ifter death. Director: After in by the fune | edical Certification; To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 | Hospital: 1 28a. Date (Mo.) 28b. Plac build hysicien: To the miner: On the | Inpatient 2 Inpati | Ulting in the u ER/Outpatier 28b. Time o Injury ome, farm, str | ndertying cause given the table of the table of the table of table | 26. Place of Deather: 4 Nursing Hory at tk? Yes 2 No | 24a. Was auto perfc 1 Yes h (Check only of the Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on C | Month Obacco use contribute of the control of the | Day Year to the cause of death? Probably 4 Linknown autopsy findings available of completion of cause of secify) Bural Route Number, as stated. se to the cause(s) |
| Division of Vital Records, P.O. Box 6 | Hospitel or Attending 4 hours after death. Funerel Director: After ely filled in by the fune | edical Certification; To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 | Hospital: 1 28a. Place (Moint) 28b. Place build hysicien: To the and ma | Inpatient 2 of Injury - At hing, etc. (Specification) of examinar stated. | ER/Outpatier 28b. Time o Injury ome, farm, str y) | nderlying cause given the state of the state | 26. Place of Deather: 4 Nursing Hory at k? Yes 2 No | 24a. Was auto perfc 1 Yes h (Check only of the Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on Check on C | Month obacco use contribute of the contribute o | Day Year to the cause of death? Probably 4 Linknown autopsy findings available of completion of cause of secify) Bural Route Number, as stated. se to the cause(s) |
| Division of Vital Records, P.O. Box 6 | To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune | edical Certification; To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 | Hospital: 28a. Date (Month of the and ma) completed cau | Inpatient 2 of Injury of Injury - At heing, etc. (Specific etc.) | ER/Outpatier 28b. Time o Injury ome, farm, str y) | nderlying cause given the second of the seco | 26. Place of Deather: 26. Place of Deather: 4 Nursing Hory at tk? Yes 2 No me, date and place, opinion, death occur se number | 24a. Was auto perfc 1 Yes h (Check only of the Check on the Check only of the Check only of the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on t | Month obacco use contribute of Yes 2 No 3 Feat and Place of Feat and Number or Feat and Place, and dual case (S) and manner and atte and place, and dual case (S) Date signed (Monte of Place o | Day Year to the cause of death? Probably 4 Linknown autopsy findings available of completion of cause of secify) Bural Route Number, as stated. se to the cause(s) |
| Division of Vital Records, P.O. Box 6 | To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune | edical Certification; To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 | Hospital: 1 28a. Data (Moi on per and ma | Inpatient 2 of Injury of Injury - At heing, etc. (Specific etc.) | ER/Outpatier 28b. Time o Injury ome, farm, str wwledge, deat attion and/or in | nderlying cause given a second of the second | 26. Place of Deather: 26. Place of Deather: 4 Nursing Hory at tk? Yes 2 No me, date and place, opinion, death occur se number | 24a. Was auto perfc 1 Yes h (Check only of the Check on the Check only of the Check only of the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on the Check on t | Month obacco use contribute of Yes 2 No 3 Feat and Place of Feat and Number or Feat and Place, and dual case (S) and manner and atte and place, and dual case (S) Date signed (Monte of Place o | Day Year to the cause of death? Probably 4 Delinknown autopsy findings available to completion of cause of us 2 No ecify) Rural Route Number, as stated. us to the cause(s) |

ORIGINAL

| | | - | For State Registrar | State | of Marylar | | artment of H | | d Mental Hy | giene Reg. No. | 006 | 379 | 96 |
|------------|--|------------------|---|----------------------|---|----------------------------------|--|-----------------------------|---|----------------------------|--------------------------------|------------------------------------|--------------|
| | | | Decedent's Name (First, Midd | le, Last) | | | | | 2. Date of De Month | | Year | 3. Time of E | |
| | Physicia /Medic | _ | LORINE | | В. | | W | DE | Novem be | 10 | 2006 | 1335 | - P M |
| | Examin | er | 4a. Facility Name (If not institution | | | | 4b. City, Town, or | | Death | _ | ounty of Death | | |
| | | | Johns Hopkins 5. Social Security Number | Bayview 6. Sex | 7. Age (In yrs. | | Balkmo If Under 1 Year | | Hrs. 8. Date of Bir | | 1 hmov | lace (State or | Foreign |
| | Funeral Director | 1 1 | 223-48-8262 | 1 □ M 2 🔁 F | | | Months Days | | Min. Oct 28 | , 1926 | Virg | nia | |
| | ס | | Usual Residence of Decedent | | 10.0 | ÷ . | | | | | | 0d. Inside City | Limite |
| | arylar show | ٦ | 10a. State 10b. Count | | | ty, Town or Lo | | | | | | 1 Tes | |
| | the M | ectc | Maryland Montg 10e. Street and Number | omery | Gai | thersb | 10f. Zip Code | | | 10g. Citizer | n of What Cour | ntry? | |
| | with with | Funeral Director | 8321 Shady Spri | ng Drive | | | 20877 | | | USA | | | |
| | death | nera | 11. Marital Status | 12. Was D | ecedent Ever in U | J.S. 13. | Was Decedent of H | lispanic Origin | ? (Specify Yes or No Puerto Rican, etc.) | - 14. | Race - Americ Black, White, | | |
| တ္ထ | or Ite | F | 1 Never Married 2 Ma | If Yes | Forces? s 2 XNo Give | | 1 ☐ Yes 2 🛣 No | | , | | pecify: Whi | | |
| 21215-0036 | within 72 hours after death with the Maryland ene. then "natural", or Items 23s or 28s-f show the Maylical Examirar most be notified at | d by | 3 NWidowed 4 □ Divorce | d Year o | r Dates: | 16a Dece | dent's Usual Occup | ation | | | of Business/In | | |
| 15 | in 72 in 72 | Completed | (Specify only high | est grade complete | | (Give | kind of work done DO NOT use retired | during most of | f working | | | , | |
| 212 | d with | mo | Elementary/Secondary (0-12) | Conleg | e (1-4or 5+) | Homem | aker | | | Own H | lome | | |
| pu | al Hygard other | 9 | 17. Father's Name (First, Middle | , Last) | | | | 18. Mother's Lola We | Name (First, Middle | , Maiden Su | ımame) | | |
| <u></u> | ould h | ို | James Boggs | | | 405 14-33 | Add (Chroat | | or Rural Route Numb | or City or T | oum State 7in | Codel | |
| Maryland | d 2 sh th and 7 is m traum | | 19a. Informant's Name/Relation | snip (Type, Print) | | | | | r. Gaithe | | | | |
| ē, | Heali Heali tem 2 | | Jim Wade/Son | | 20b. | | sition (Name of matory or other plan | | Date | | tion - City or T | | |
| D D | Pages ent of nt: If I | | 1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (| | om State | | ke Cremat | | 1/13/06 | Belts | ville, | MD | |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show amportant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show amply injury or other traumatic event, the Marical Examinat must be notified at once. | | 21. Signatu Funeral Service | a Licensee/ | 211 | Ĝ | 2. Name and Addre | ss of Facility | tion Serv | | | | 21000 |
| | 40 ± ● d | Ш | 23a, Part1, Enter the disease, | or complications th | | | | | otte, P.A. | | ksvill | Approximate | 9 |
| | Dhysisian | | shock, or heart failure. List Immediate Cause (Final | st only one cause of | on each line. | | | | | | | Onset and D | |
| 8 | Physician /Medical | | disease or condition resulting in death) | a. Fu | monay to (or as a conse | quence of): | mzilox | | | | | | |
| П | Examiner | | Seventially list conditions. | | ulure to | | د | | | | | | |
| | sit ad | iner | S yentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | cart fo | | | | | | | | |
| | death certificate be executed e attending physicien and of for use as the burial-transit | Examine | that initiated events resulting in death) Last | U. | to (or as a conse | | - | | | | | | |
| 1,092 | e be e rsicien e burit | ical | | d | | | | | | | | | |
| 89 | tificate og phy as the | ledic | | | | | | 10 | 0.000 | | | | |
| Вох | death certific attending players as to | an/N | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | | outcome of pregr ve birth 2 ☐ Fet | al death 3 | Ectopic pregnanc | y | | 230 | d. Date of deliv Month | • | 'ear |
| | at the dea by the at tached fo | Physician/Med | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | | regnant at time of nknown | death 5(| Other (specify) | | | | | , | |
| P.0 | g g g | | Part II. Other significant condi | tions contributing | to death but not re | sulting in the I | ınderlying çause gı | ven in Part I. | 23e. Did | tobacco use | contribute to | he cause of d | eath? |
| Records, | n sign | d by | | | | | | | 10 | Yes 2□ | No 3□Pro | bably 4 | nknown |
| 000 | s been s shoul | Completed | | | | | | | 24a. Was | | 24b. Were aut | opsy findings a empletion of ca | available |
| æ | The lav | E | | | | | | | perf 1 ☐ Yes | ormed? 2 No | death? 1 ☐ Yes | | |
| Vital | ilcian: Th certificate rector, pag | Be | 25. Was case referred to medic | | | | l ou | | of Death Check only | one) | | | |
| of \ | S 5 | ၉ | 1 Yes 2 No | | | 28b. Time | nt 3LI DOA | | ing Home 5 Res | | | fy) | |
| | fing After fune | tion | 1 Natural 5 Pend | ding (f | ate of Injury Month, Day Year) | Injury | Wo | rk?]Yes 2∐No | | | | | |
| Division | Attending or death. ector: After by the fune | fica | 3 Suicide 6 Coul | d not be 28e. P | lace of Injury - At | home, farm, s | reet, factory, office | | 28f. Location | (Street and i | Number or Rui | al Route Num | ber, |
| ā | rs afte si Dir ed in I | Certification: | 4 Homicide | | uilding, etc. (Spec | | | | Only G 7 | mi, oluto) | | | |
| | To the Hospital or Attans within 24 hours after death To the Funeral Director: completely filled in by the | Medical | 29a. Certifier 1 Certific (Check only one) | al Examiner: On the | the best of my kr ne basis of examin manner stated. | nowledge, dea nation and/or i | th occurred at the to nvestigation, in my | me, date and opinion, death | place, and due to the occurred at the time | cause(s) a , date and p | nd manner as lace, and due | stated. to the cause(s |) |
| | o the | Med | 29b. Signature and title of certific | | namor statod. | | 29c. Licen | se number | | 29d. Date | signed (Month | Day, Year) | |
| | - > P U | | 1 /aby | Ma | | | RES | -000 | | Nove | mber 1 | 0,200 | >6 |
| 6 | 50 | | 30. Name and address of person | | _ | | | | | | | | |
| ¥ | | | DR FASHOYIN 31. Date filed (Month, Day, Yea | <u>) 494</u> | 2 Rafistrar's Sign | nature | | alhmo | re, MD 3 | コレム | t | | |
| | St Regist | ate trar | NOV 1 | | Meser | K. | Society) | | | | | | |
| | | | | | | | - | | | | | | |

| | 7 | - Stata Registrar | | | imouto | of De | alli | | | No. | | |
|--|--|--|--|--|--|--|--|--|--|---|--|---|
| nysician | | 1. Decedent's Name (First, Middle, La | | | | | | 2. Date of Month | | Day | Year | 3. Time of Death |
| Medical | 1 | ANNE WAR | | | 4b City T | Four or Loc | cation of Deat | NOV. | 10 | 4c. County o | | 1700 |
| xaminei | r 4 | 4a. Facility Name (If not institution, given HERON POINT | e street and number) | | | STERTO | | | | KE | | |
| neral ector | | 5. Social Security Number 6. S | Sex 7. Age (In yr | s. last birthday) Yrs. | If Under 1 Months | | Under 24 Hrs. Hours Min. | | Day, Ye | ear) | Cour | lace (State or Fore htry) AWARE |
| 18.83 | - | Usual Residence of Decedent 10a, State 10b, County | 10c. | City, Town or Lo | ocation | | | | | | 1 | Od. Inside City Lin |
| trian natural, or teme 23s of 28s and the Medical Examiner must be notified at | 1 | | ANNE | CENTRE | | | | | | | | 1 X Yes 2 🗌 |
| THOU S | Director | 10e. Street and Number | | | 10f. Zip 0 | | _ | | 10g. | . Citizen of W | hat Cour | ntry? |
| The least | a D | 208 BELVEDERE A | VENUE | | | | 21617 | | U | SA | | |
| T I | Funeral | 11. Marital Status | 12. Was Decedent Ever in Armed Forces? | U.S. 13. | Was Decede If Yes, specif | ent of Hispa ify Cuban, N | anic Origin? (S Mexican, Puer | specify Yes of to Rican, etc. | r No- .) | | - Americ k, White, | ean Indian, etc. |
| a diameter | by Fi | 1 Never Married 2 Marned 3 Widowed 4 Divorced | 1 ☐ Yes 2 📉 No ff Yes, Give Year or Dates: | | 1 🗆 Yes 2 | No S | Specify: | | | Specify: | W | HITE |
| CalE | | 15. Decedent's E | ducation | 16a. Dece | dent's Usual | l Occupation | n ing most of wo | rkina | 16 | b. Kind of Bus | siness/In | dustry |
| Wadin of | Completed | (Specify only highest gra Elementary/Secondary (0-12) | College (1-4or 5+) | `life. | DO NOT use | e retired) | ng most of wo | ining | | A DIFF | | |
| other th | 5 | 12 | 4 | AI | RTIST | 10 | 3. Mother's Na | ma /First Mi | ddie Ma | ART | a) | |
| 2 e 1 | ă | 17. Father's Name (First, Middle, Last IRVING WARNER | | | | 10. | MARIO | | LMAN | | 9) | |
| other traumatic ev | ၉ | 19a. Informant's Name/Relationship (| | 19b. Maili | ing Address | (Street and | Number or R | ural Route N | umber, C | City or Town, S | State, Zip | Code) |
| 27 le | | CHARLES M. WEST, | | 8180 | MANIT | OBA S | T., AP | г.233, | PLA | YA DEL | REY | , CA 902 |
| r other | 8 | 20a. Method of Disposition 1 | | p. Place of Disponentery, cre | matory or oth | ther nlace) | | Date | | c. Location - (| | |
| ury or of | - | 4 Donation 5 Other (Special | | HESTERF | TELD (| CEMETI | ERY 11- | -15-200 | 36 C | ENTKEV. | Լեեբ | , MD |
| Important: any injury o once. | I | 21. Signature of Funeral Service Life | nsee | _ 2 | 2. Name and | d Address o | of Facility | & NEW | NAM | FUNERA | J. HO | ME, P.A. |
| | | (ARIC | 641) | FI | ELLOWS | , HELF | ENDETH | CENT | DEVI | TIF M | m 21 | 617 |
| | | 23a. Part1. Enter the disease, or com | nplications that caused the de | 41 | 08 S. | LIBER | TY ST. | , CENT | REVI | LLE, M | D 21 | Approximate |
| - 1 4. | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only fmmediate Cause (Final | one cause on each line. | eath. Do not en | 08 S. Inter the mode | LIBER e of dying, s | TY ST | c or respirate | REVI | I.I.E., M | D 21 | 617 |
| sician edical | | 23a. Part1. Enter the disease, or comshock, or heart failure. List only | nplications that caused the dry one cause on each line. a. END-STA Due to (or as a cons | eath. Do not en | 08 S. Inter the mode | LIBER e of dying, s | TY ST | c or respirate | REVI | I.I.E., M | D 21 | Approximate finterval Between |
| sician | | 23a. Part1. Enter the disease, or comshock, or heart failure. List only fmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, | a. END-STA Due to (or as a cons | eath. Do not en | 08 S. Inter the mode | LIBER e of dying, s | TY ST | c or respirate | REVI | I.I.E., M | D 21 | Approximate finterval Between |
| sician edical miner | liner | 23a. Part1. Enter the disease, or comshock, or heart failure. List only famediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First Undertying | one cause on each line. | eath. Do not en | 08 S. Inter the mode | LIBER e of dying, s | TY ST | c or respirate | REVI | I.I.E., M | D 21 | Approximate finterval Between |
| sician edical miner | | 23a. Part1. Enter the disease, or comshock, or heart failure. List only tmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | a. END-STA Due to (or as a cons | GE A sequence of): | 08 S. Inter the mode | LIBER e of dying, s | TY ST | c or respirate | REVI | I.I.E., M | D 21 | Approximate finterval Between |
| sician edical miner | Examin | 23a. Part1. Enter the disease, or comshock, or heart failure. List only finmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | a. END-S TA Due to (or as a cons b. Due to (or as a cons c. | GE A sequence of): | 08 S. Inter the mode | LIBER e of dying, s | TY ST | c or respirate | REVI | I.I.E., M | D 21 | Approximate finterval Between |
| ohysician and the burial-transit the burial-transit | dical Examin | 23a. Part1. Enter the disease, or comshock, or heart failure. List only famediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. END-S TA Due to (or as a cons b. Due to (or as a cons c. | GE A sequence of): | 08 S. Inter the mode | LIBER e of dying, s | TY ST | c or respirate | REVI | I.I.E., M | D 21 | Approximate finterval Between |
| ohysician and the burial-transit the burial-transit | dical Examin | 23a. Part1. Enter the disease, or comshock, or heart failure. List only findediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. END-S TA Due to (or as a cons b. Due to (or as a cons c. | eath. Do not en GE A sequence of): sequence of): gnancy | 08 S. Inter the mode | LIBER e of dying, s ELME | TY ST | c or respirate | REVI | LILE, M | D 21 | Approximate finterval Between Onset and Death |
| ohysician and the burial-transit the burial-transit | dical Examin | 23a. Part1. Enter the disease, or composition of the part failure. List only find disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2950 | b. Due to (or as a cons C. Due to (or as a cons d. 23c. If yes, outcome of pre | gnancy etal death 3 | 08 S. Inter the mode | LIBER e of dying, s ELME | TY ST | c or respirate | REVI | LLE, M | D 21 | Approximate finterval Between Onset and Death |
| y the attending physician and actions as the burial-transit use as the burial-transit | Physician/Medical Examin | 23a. Part1. Enter the disease, or comshock, or heart failure. List only femediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 SNo 9 Unknown | b. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome of pre 1 \(\text{Live birth} \) 2 \(\text{F} \) 4 \(\text{Pregnant at time } \text{c} \) 9 \(\text{Unknown} \) | gnancy et al death 5 f death 5 f death 5 not en | D8 S Inter the mode LZ H E □ Ectopic pre □ Other (spec | e of dying, s | EVS | CENT c or respirate | REVI | 23d. Date | e of deliv | Approximate finterval Between Onset and Death |
| gned by the attending physician and be detached for use as the burtal-transit | by Physician/Medical Examin | 23a. Part1. Enter the disease, or composition of the part failure. List only find disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2950 | b. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome of pre 1 \(\text{Live birth} \) 2 \(\text{F} \) 4 \(\text{Pregnant at time } \text{c} \) 9 \(\text{Unknown} \) | gnancy et al death 5 f death 5 f death 5 not en | D8 S Inter the mode LZ H E □ Ectopic pre □ Other (spec | e of dying, s | EVS | CENT correspirate | REVI | 23d. Date Mor | e of deliverth | Approximate finterval Between Onset and Death > 3 year |
| gned by the attending physician and be detached for use as the burtal-transit | by Physician/Medical Examin | 23a. Part1. Enter the disease, or comshock, or heart failure. List only femediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 SNo 9 Unknown | b. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome of pre 1 \(\text{Live birth} \) 2 \(\text{F} \) 4 \(\text{Pregnant at time } \text{c} \) 9 \(\text{Unknown} \) | gnancy et al death 5 f death 5 f death 5 not en | D8 S Inter the mode LZ H E □ Ectopic pre □ Other (spec | e of dying, s | EVS | CENT c or respirate DISC | Did toba | 23d. Date Mor | e of deliverable to to 3 Pro | Approximate interval Between Onset and Death Between Onset and Death Day Pery Day Year The cause of death bably 4 □Unkn |
| is been signed by the attending physician and 2 should be detached for use as the burial-transit Lead to the contract of the | by Physician/Medical Examin | 23a. Part1. Enter the disease, or comshock, or heart failure. List only femediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 SNo 9 Unknown | b. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome of pre 1 \(\text{Live birth} \) 2 \(\text{F} \) 4 \(\text{Pregnant at time } \text{c} \) 9 \(\text{Unknown} \) | gnancy et al death 5 f death 5 f death 5 not en | D8 S Inter the mode LZ H E □ Ectopic pre □ Other (spec | e of dying, s | EVS | CENT c or respirate DISC | Did toba | 23d. Date Mor | e of deliverable of the state o | Approximate finterval Between Onset and Death > 3 year Day Year Day Year the cause of death bably 4 Unknopsy findings availampletion of cause |
| is been signed by the attending physician and 2 should be detached for use as the burial-transit Lead to the contract of the | e Completed by Physician/Medical Examin | 23a. Part1. Enter the disease, or comshock, or heart failure. List only find failure. List only find failure. List only find failure. List only find failure. List only find failure. List only find failure. List only find failure. List only find failure. List only find failure. List only find failure. List only find failure. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ □ No. 9 □ □ Unknown Part II. Other significant conditions | b. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome of pre 1 \(\text{Live birth} \) 2 \(\text{F} \) 4 \(\text{Pregnant at time } \text{c} \) 9 \(\text{Unknown} \) | gnancy et al death 5 f death 5 f death 5 not en | D8 S Inter the mode LZ H E □ Ectopic pre □ Other (spec | egnancy ecity) | EVS | 23e. | Did tobac The second of the s | 23d. Date Mor | e of delivinth ibute to t 3 Prol Vere autorior to ccieath? | Approximate interval Between Onset and Death Between Onset and Death Day Pery Day Year The cause of death bably 4 □Unkn |
| is been signed by the attending physician and 2 should be detached for use as the burial-transit Lead to the contract of the | Be Completed by Physician/Medical Examin | 23a. Part1. Enter the disease, or conshock, or heart failure. List only finmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Disease of the past 12 months? 1 Yes 2 Disease of the past 12 months? 1 Yes 2 Disease of the past 12 months? 1 Yes 2 Disease of the past 12 months? 1 Yes 2 Disease of the past 12 months? 1 Yes 2 Disease of the past 12 months? 1 Yes 2 Disease of the past 12 months? 1 Yes 2 Disease of the past 12 months? 1 Yes 2 Disease of the past 12 months? 1 Yes 2 Disease of the past 12 months? 1 Yes 2 Disease of the past 12 months? 1 Yes 2 Disease of the past 12 months? 1 Yes 2 Disease of the past 12 months? 1 Yes 2 Disease of the past 12 months? 1 Yes 2 Disease of the past 12 months? 1 Yes 2 Disease of the past 12 months? 1 Yes Disease of the past 12 months? 1 Yes Disease of the past 12 months? 1 Yes Disease of the past 12 months? 1 Yes Disease of the past 12 months? 1 Yes Disease of the past 12 months? 1 Yes Disease of the past 12 months? 1 Yes Disease of the past 12 months? 1 Yes Disease of the past 12 months? 1 Yes Disease of the past 12 months? 1 Yes Disease of the past 12 months? 1 Yes Disease of the past 12 months? 1 Yes Disease of the past 12 months? 1 Yes Disease of the past 12 months? 1 Yes Disease of the past 12 months? 1 Yes Disease of the past 12 months? 1 Yes Disease of the past 12 months? 1 Yes Disease of the past 12 months? | b. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. Due to (or as a cons d. Due to (or as a cons d. Due to (or as a cons consider the cons d. Due to (or as a cons d. | gnancy et al death 5 f death 5 f death 5 not en | D8 S Inter the mode LZ H E □ Ectopic pre □ Other (spe | egnancy egrancy eucity) ause given i | in Part I. | 23e. | Did tobal 1 Yes Was an autoparforms (es. 25) | 23d. Date Mor | e of delivinth sibute to to the sibute to t | Approximate finterval Between Onset and Death Between Onset and Death Day Year The cause of death bably 4 Dunkn Day Yindings available of cause No |
| is been signed by the attending physician and 2 should be detached for use as the burial-transit Lead to the contract of the | To Be Completed by Physician/Medical Examin | 23a. Part1. Enter the disease, or conshock, or heart failure. List only finded to the condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death | b. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. Due to (or as a cons d. Pregnant at time of public death but not | gnancy etail death 5 feeduling in the | DS S | egnancy egrancy eucity) ause given i | in Part I. | 23e. 24a. 1 Check of the Check | Did tobal 1 Yes Was an any performs (es. 25) Resident | 23d. Date Mor | e of deliverable of the state o | Approximate finterval Between Onset and Death Between Onset and Death Day Year The cause of death bably 4 Dunkn Day Yindings available of cause No |
| is been signed by the attending physician and 2 should be detached for use as the burial-transit Lead to the contract of the | To Be Completed by Physician/Medical Examin | 23a. Part1. Enter the disease, or conshock, or heart failure. List only findediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No No No 27. Manner of Death Yes Accident No 28. No No 29. Accident No 20. Pending investigation No 20. Pending investigation No 20. Accident No 20. Pending investigation No 20. Pending investigation No 20. Pending investigation No 20. Pending investigation No 20. Pending investigation No 20. Pending investigation No 21. Pending investigation No 22. Pending investigation No 23. Pending investigation No 24. Pending investigation No 25. Pending investigation No 26. Pending investigation No 27. Pending investigation No 28. Pending investigation No 29. Pending investigation Pe | b. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. Due to (or as a co | gnancy etal death 3 of death 5 resulting in the liqury 28b. Time Injury | OR S. Inter the mode - LZ H E - LZ H E - LZ H E - LZ H E - Determine the mode - D | egnancy ecity) ause given i Other: 8c. Injury at Work? 1 Yes | in Part I. | 23e. 24a. 1 1 28d. Desc | Did tobal | 23d. Date Mor | e of deliventh sibute to to a proof of the content | Approximate finterval Between Onset and Death > 3 year ery Day Year the cause of death bably 4 Dunkn opsy findings avail ampletion of cause 2 No |
| is been signed by the attending physician and 2 should be detached for use as the burial-transit Lead to the contract of the | To Be Completed by Physician/Medical Examin | 23a. Part1. Enter the disease, or conshock, or heart failure. List only finded to the condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death that was the shock of the conditions. | b. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. Due to (or as a cons d. Pregnant at time of Unknown Contributing to death but not Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) | gnancy etail death 5 granular from the sequence of): Sequence of) | OR S. Inter the mode - LZ H E - LZ H E - LZ H E - LZ H E - Determine the mode - D | egnancy ecity) ause given i Other: 8c. Injury at Work? 1 Yes | in Part I. | 23e. 24a. 1 Neath Check of Home 5 Neath 28d. Description | Did tobal | 23d. Date More Cco use control 275 No 24b. V do 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | e of deliventh sibute to to a proof of the content | Approximate finterval Between Onset and Death Between Onset and Death Day Year The cause of death bably 4 Dunkn Day Yindings available of cause No |
| Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit to be burial-transit. | Certification: To Be Completed by Physician/Medical Examin | 23a. Part1. Enter the disease, or conshock, or heart failure. List only finmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Yes 2 Accident 3 Suicide 4 Homicide 4 Certifying Parently 4 Certifying Parent | b. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown Contributing to death but not 1 Inpatient 2 28a. Date of Injury (Month, Day Year be defined by the consequence of | gnancy sequence of): gnancy sequence of): gnancy sequence of): gnancy setal death 3 of death 5 of death 6 o | DECtopic pre Other (special value) of Metreet, factory | egnancy egnancy ecrity) ause given i Other: 28c. Injury at Work? 1 Yes | in Part I. | 23e. 24a. 1 28d. Description of the control of th | Did tobac Did tobac Tyes Was an autopsy performer Fes 25 Diff on (Streen Town) To the cau | 23d. Date Mor 23d. Date Mor 25No 24b. V 24b. V 24b. V 24b. V 25ce 6 | e of delivinth ribute to t 3 Prol Were autorior to codeath? er (Special er or Rur | Approximate finterval Between Onset and Death Bally 4 Dunkn Death Day Year The cause of death bably 4 Dunkn Death Day Findings available on Cause Route Number, stated. |
| I Francial Director: After this certificate has been signed by the attending physician and up in the state of | Certification: To Be Completed by Physician/Medical Examin | 23a. Part1. Enter the disease, or conshock, or heart failure. List only finmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Yes 2 Accident 3 Suicide 4 Homicide 4 Certifying Parently 4 Certifying Parent | b. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. Due to (or as a cons d. Due to (or as a cons d. Pregnant at time of pregnant at time o | gnancy sequence of): gnancy sequence of): gnancy sequence of): gnancy setal death 3 of death 5 of death 6 o | DECtopic pre Other (special value) of Metreet, factory | egnancy egnancy ecrity) ause given i Other: 28c. Injury at Work? 1 Yes | in Part I. | 23e. 24a. 1 28d. Description of the control of th | Did tobac Did tobac Tyes Was an autopsy performer Fes 25 Diff on (Streen Town) To the cau | 23d. Date Mor 23d. Date Mor 25No 24b. V 24b. V 24b. V 24b. V 25ce 6 | e of delivinth ribute to t 3 Prol Were autorior to codeath? er (Special er or Rur | Approximate finterval Between Onset and Death Bally 4 Dunkn Death Day Year The cause of death bably 4 Dunkn Death Day Findings available on Cause Route Number, stated. |
| rel Director. After this certificate has been signed by the attending physician and up in the funeral director, page 2 should be detached for use as the burial-transit and up to be the funeral director, page 2 should be detached for use as the burial-transit and page 2. | To Be Completed by Physician/Medical Examin | 23a. Part1. Enter the disease, or conshock, or heart failure. List only finmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 2 No 25 Was case referred to medical examiner? 1 Yes 2 No 27 Manner of Death 1 Yes 2 No 28 No 29 No 29 Certifier 1 Certifying P Check only 2 Medical Examiner | Due to (or as a constant line) a. END - STA Due to (or as a constant line) b. Due to (or as a constant line) c. Due to (or as a constant line) d. Pregnant at time of pregnant at time of pregnant line) 28a. Date of Injury (Month, Day Year) Physician: To the best of my aminer: On the basis of exament and manner stated. | gnancy etail death 3 of death 5 leavence of): Sequ | on the mode of the | egnancy ecify) ause given i Other: 28c. Injury at Work? 1 Yes y, office at the time, in my opini | in Part I. | 23e. 23e. 24a. 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local | Did tobar | 23d. Date More 23d. Date More 24b. V 24b. | e of deliverable of the standard due in the st | Approximate finterval Between Onset and Death > 3 year ery Day Year the cause of death bably 4 Dunkn Dopsy findings avail project of the cause of |
| I Francial Director: After this certificate has been signed by the attending physician and up in the state of | Certification: To Be Completed by Physician/Medical Examin | 23a. Part1. Enter the disease, or conshock, or heart failure. List only finmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 2 No 25 Was case referred to medical examiner? 1 Yes 2 No 27 Manner of Death 1 Yes 2 No 28 No 29 No 29 Certifier 1 Certifying P Check only 2 Medical Examiner | Due to (or as a constant of the best of my aminer: On the basis of exam. | gnancy etail death 3 of death 5 leavence of): Sequ | on the mode of the | egnancy ecify) ause given i Other: 28c. Injury at Work? 1 Yes y, office at the time, in my opini | in Part I. | 23e. 23e. 24a. 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local 28f. Local | Did tobar | 23d. Date More Cco use control 25No 24b. V od? I No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | e of deliverable of the standard due in the st | Approximate finterval Between Onset and Death > 3 year ery Day Year the cause of death bably 4 Dunkn Dopsy findings avail project of the cause of |
| I Francial Director: After this certificate has been signed by the attending physician and up in the state of | Certification: To Be Completed by Physician/Medical Examin | 23a. Part1. Enter the disease, or conshock, or heart failure. List only finmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 2 No 25 Was case referred to medical examiner? 1 Yes 2 No 27 Manner of Death 1 Yes 2 No 28 No 29 No 29 Certifier 1 Certifying P Check only 2 Medical Examiner | Due to (or as a constant of the constant of th | gnancy etal death 5 grequence of): gnancy etal death 5 grequence of): grequence of): gnancy etal death 5 grequence of): grancy etal death 5 grequence of): | DEctopic pre Other (specific pre) Other (specific pre) Other (specific pre) Other (specific pre) and 3 DO of M Street, factory ath occurred a investigation, 29c | egnancy egrancy ecrity) ause given i Other: 1 | in Part I. 16. Place of De 4 Nursing t s 2 \(\text{No} \) date and place inon, death occurrence with the construction of th | 23e. 24a. 1 28d. Description 28d. Desc | Did tobal Did tobal Tyes Was an average of the control of the cautime, date | 23d. Date More 23d. Date More 24b. V 24b. | e of deliverable of the standard due in the st | Approximate finterval Between Onset and Death > 3 year ery Day Year the cause of death bably 4 Dunkn Dopsy findings avail project of the cause of |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37999 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** AM Vovembae 2006 /Medical 45 City, Town, or Location of Death 4c. County of Death Facility Name of not institution, give street and number) Examiner Couthorn Mary And 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday)) to If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days 1 □ M 2 X F Months 220 40-7464 Usual Residence of Decedent Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "neturel", or Items 23a.or 28a-1 ehow 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic avent, the Medical Examinar must be notified at NYes 2 No Completed by Funeral Director BEAND WINCE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code e SA 1061 2061 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐Yes 2 ☐ No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ff Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Slack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 03/11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FURO JOHN MAUda ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 it HUSBANC 10611 CEOSS ROAD TEAL BEAUCHWINE MARY PANCE 20613 William Necla other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Its any injury or of 1 Burial 2 □ Cremation 3 □ Removal from State 11-9-2006 SURRICHON 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Adams Funcer Home P. A 20605 Aguasco Road Aguasco Mary land 2060 8 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsey and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list non-flicing if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 X No certificete Josposo 1 ☐ Yes Te the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To his After thi 27. Manner of De th 28c. Injury at Work? 28a. Dote of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending within 24 hours after death.
To the Funeral Director: Al 1 🗌 Yes 2 □ No investigation 6 ☐Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier welch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month,

= ON

2006

32. Redistrar's Signature

State of Maryland / Department of Health and Mental Hygiene [] [] [38000 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 053CM **Physician** Eloise Viola Workman OV 2006 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MALLARD BAY CARE CENTER CAMBRIDGE DORCHESTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 1/25/1916 Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F 90 Yrs. 150-07-2340 New York Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Items 23a or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If item 27 is marked other than "natural", or litems to an interiouslibe an interiouslibe an interiouslibe and any or other traumatic event, the Model Examiner must be notified. 1X Yes 2 No Maryland Dorchester Cambridge Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 206 Meteor Road 21613 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Specify 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Medical 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edward A. Beyer Emma H. Drager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Darlene Kent/daughter 5142 Paw Paw Rd., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/8/06 Salisbury Crematory Salisbury, MD * 4 □ Donation 5 □ Other (Specify) 21. Sigrature of Funeral Service Licensee ²² Name and Address of Facility
HOLLOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 011/0 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the at d be detached fo Yes 20 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an page 2 s certificate 1 Yes 2 PNO or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 2 ER/Outpatient 1 ☐ Yes 2 No 1 ☐ Inpatient 3 DOA 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 Accident 5 Pending investigation within 24 hours are. To the Funeral Director: Att 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie e U

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) NOV 0 9 2006

30. Name and address

Miche

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

302